AAID president-elect named vice dean at Harvard School of Dental Medicine

By Dental Tribune America

NEW YORK, USA: After an extensive nationwide search, AAID President-Elect John Da Silva, DMD, MPH, ScM, AFAAID, has been named vice dean at Harvard School of Dental Medicine. Dean Bruce Donoff stated that Da Silva’s “extensive institutional knowledge and experience in [HSDM’s] three focal areas — research, education and patient care — will be of great value as HSDM continues its strategic planning process.”

Da Silva serves on the board of trustees of the American Academy of Implant Dentistry and is currently the president-elect. He is also chair of the Bylaws Committee and serves on the Education Oversight and Nominating committees. He has received widespread recognition during his academic career, including being named an honored fellow of the American Academy of Implant Dentistry and receiving the HSDM Distinguished Junior Faculty Award.

He has published numerous journal articles and lectured nationwide. Da Silva has made major contributions in research and the area of color science. He has also been involved in curricular changes to improve content on substance-abuse screening and brief interventions.

Da Silva was born in New York City and attended Williams College as an undergraduate. He received his dental degree from the Harvard School of Dental Medicine and his MPH degree from the Harvard School of Public Health. He later returned to the School of Public Health and received an ScM in health policy and management.

Da Silva completed specialty training in implant dentistry and prosthodontics at HSDM in 1992. He has been a faculty member there since 1995.
Fellows at the ceremony: from left: Abdullah Al Kradees, Dhad Abdallah, Hanu Ouns, Moustier Silwadi, guest Dr Youssef Al Khoudair, Abdalghanii Mira, Youssef Talei and Ziad Salameh.

President Riad Bacho gave a brief word and then handed over the presidency medal to President Ali Aheiaideh.

President Aheiaideh thanked all those present as well as the event sponsors and praised the work of fellow Youssef Talei, the section’s past vice president, who had done the groundwork for the organization of District 2.

Councilor Cedric Haddad also gave an update of the activities of the International Council and of the changes that were taking place in the College.

Mr Elie AbouChedid then introduced his company (CARE) and gave a presentation of the technically advanced services that it provided.

A banquet followed the meeting and gave all those present the chance to socialize, renew acquaintance and exchange ideas.

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**Planmeca makes CAD/CAM easier than ever**

By Petri Kajander

Planmeca’s open-inter-face-based CAD/CAM solutions introduce, above all, quality, cost-efficiency and precision to the daily workflow at dental clinics or laboratories. Petri Kajander, Product Manager for Planmeca’s CAD/CAM solutions, explains the revolutionary features of these new products.

State-of-the-art solutions for dentists

Planmeca PlanScan® – super-fast intraoral scanner

The new Planmeca PlanScan® is a digital and powder-free intraoral scanner that scans the patient’s dentition quickly and accurately. The scanner produces real-time digital impressions from one-tooth to full-arch scans. Thanks to the open STL data, the scanned files can be sent to any dental laboratory. For this reason, Planmeca’s system is seamlessly integrated in Planmeca Romexis® software and it is a user-friendly design tool for the design of inlays, onlays, veneers, crowns and bridges.

“The software runs on the so-called floating licence basis. This means that it is not tied to just one computer or workstation but the work is saved on the Planmeca Romexis server. In this way, the scanning station can be used only for scanning, while another workstation is used for the actual design work. This is a truly unique feature, which allows work to be continued straight away on another computer, while the scanner is freed for more productive operation”, says Kajander.

Every dentist designing his or her own prosthetic works will also face cases that require assistance from a dental laboratory. For this reason, Planmeca’s system utilises an open STL file format that allows the work to be sent immediately to a partner via the Planmeca Romexis® Cloud service.

Since Planmeca PlanCAD® Easy is seamlessly integrated in Planmeca Romexis® software and it is a user-friendly design tool for the design of inlays, onlays, veneers, crowns and bridges.

Planmeca PlanCAD® Easy – efficient design tool for prosthetics

Planmeca also offers dentists a new kind of open software solution for 3D design. Planmeca PlanCAD® Easy is seamlessly integrated in Planmeca Romexis® software and it is a user-friendly design tool for the design of inlays, onlays, veneers, crowns and bridges.
plant planning, for example, because in addition to the soft tissues, it visualises the crown that is designed for the occlusion. This facilitates the planning of the implant screw’s location.

The Planmeca PlanCAD Easy workflow from preparation to the finished result includes just five easy stages: work description, scanning, marking of the margin line, automatic design, and sending the work to the mill. “Once the work has been sent to the mill, it is transferred there in its entirety and the mill’s computer finishes the work. In this way, the software and scanner are immediately freed for a new assignment.”

The software is very user-friendly. All design phases are saved automatically, and if further impressions are needed, previous phases can be returned to flexibly. The automatic design software automatically takes into account the adjacent teeth’s cusps and marginal ridge in addition to the contact strengths defined by the user. This creates a design that always fits its surroundings.

Planmeca PlanMill® 40 – fast and precise milling unit for dental clinics

Planmeca PlanMill® 40 is an extremely precise four-axis milling unit operating under the control of its own computer. The device is suitable for all the indications of a single tooth, in other words for the milling of crowns, inlays, onlays and veneers. The mill can manage bridges of up to five units to the posterior and three units to the anterior area.

Since the mill handles the milled pieces completely independently, as many as several dozen pieces can be sent to the mill at a time. In addition, the device tells which block size, colour and material should be used, so any member of the staff can place the block in the mill. “This saves everyone’s working time. The dentist does not need add the block himself, but anyone can do it”, says Kajander.

The mill has a six-tool exchange mechanism, and it changes tools independently according to different job requirements. In addition, the device mills different materials according to their properties. For example, it knows how to gently handle delicate ceramics in work phases that require precision. “If you force the material, it may break prematurely. Even the smallest hairline crack in the material can lead to a cemented piece breaking when

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Interview: “Kennedy’s wound was clearly incompatible with life”

When I looked up lat-
er, the room was filled with the senior chiefs of all surgical depart-
ments at Parkland. There were also some people I did not know.

Where was the atmosphere in the room? It became very quiet. Nobody said anything.

In your opinion, was there any chance that the president’s life could have been saved? Nothing that we did made a difference. Kennedy’s wound was clearly incompatible with life.

According to eyewitnesses, discussions broke out about who was authorized to do the autopsy. Did you notice any of that?

I did not because I left the trauma room soon after the president had been pro-
nounced dead and went back to the clinic to see my patient in the operating room. How-
ever, I found that all scheduled surgeries for that day had been canceled and all patients had been sent back to the ward. Only a few surgeries were un-
derway at that time, including that of Governor John Bowden Connally, who had also been injured during the shooting.

We were aware of the presi-
dent being in Dallas on 22 No-
vel 1963. I was not aware of that and was surprised when they brought him to the hospital. I had a surgery scheduled for later that day and was on my way to have lunch. The tray to my lunch-room how-
erver required me to leave the building and walk across the receive area of the emer-
gency room, where I noticed police cars and the presiden-
tial limousine, which had blood on it and roses that were given to the first lady, Jacqueline Kennedy, when she arrived at the airport.

When a policeman asked me whether I was a doctor, I said yes. He then replied that the president was hurt and escorted me to the trauma room where President Ken-
ney was.

In what condition was Ken-
tedy when you arrived?

When I got there, it was obvi-
ous that the president was in extremis. He tried to breathe but was unable to do so. Dr. Charles James Carrico, a Parkland resident surgeon, had placed an endotracheal tube in an attempt at ven-
tilation. However, that did not work because there was a blockage of the president’s airway, so he decided to do a tra-
cheostomy.

I helped the nurse to undo the president’s tie and remove his shirt to prepare him for the procedure. Then Dr. Malcolm Perry, a senior surgeon, came into the room and it was decid-
ed that he should do the tracheostomy. Dr. Car-
rico assisted Dr. Perry, and I performed a cut-
down on the left leg to provide for intravenous replacement of blood.

I told my patient that her sur-
gery had been postponed. She understood that. Since there was nothing else for me to do, I then cleared my business in the clinic and went home. There, we spent the week-
end watching television and listening to the news on the radio. We were relieved that President Lyndon B. John-
son had made it safely back to Washington and that the gov-
ernment was uninterrupted.

Finally on Sunday, we learned that the suspect, Lee Harvey Oswald, had been shot, which indicated that there was something going on in addition to just alone shooter.

My personal belief is that there were of course multiple shooters and that Oswald did not do it alone. This would indicate however that there was in fact a conspiracy.

What do you believe actually happened that day?

My personal belief is that there were of course multiple shoot-
ers and that Oswald did not do it alone. This would indicate however that there was in fact a conspiracy.

After the events, you stayed at Parkland Memorial Hospital for another two years. Were the events still discussed by the staff in the aftermath?

We actually never talked about it. This was something we just did not want to discuss. How-
ever, I left Parkland in 1965 for an exchange residency in Lon-
don and Zurich, where I often discussed the events with my colleagues abroad. Particular-
ly in England, there was much more interest in U.S. politics and the assassination.

You recently went public with your knowledge after 50 years. What were your reasons for do-
ing so?

Everything that I would say is already in the literature about the assassination but I think there needs to be general knowledge of what people who were actually involved knew.

More than six million pages of classified evidence on the Ken-
ney assassination are going to be released by 2017. Are you interested in this knowledge, or do you consider that chapter of your life closed?

There is a great deal of spec-
ulation of what information these documents actually con-
tain. I do not look forward to it but would be interested to know what could be learned from them.

Thank you very much for the interview.
However, just as the Internet has changed dentist workflow. Aditional concept of a laboratory/dentist partnership for fabrication and delivery. This partnership is sent back to the dentist for finishing, firing, third, ceramics, day four, etc. Average production time for an all-ceramic or porcelain-fused-to-metal restoration is approximately five to seven working days based on this fabrication method.

In the digital laboratory, impressions will still be received from the patient. Instead of taking days or weeks to go through several processes, we will be able to accomplish the same process in two to three days. Once the impression is received at the laboratory, the impression can be scanned and data sent to several digital production stations at the same time. This will potentially allow the model, the restorations (both framework and waxup) and the final ceramic restoration to be completed at the same time (Fig. 6).

Digital diagnostic and treatment planning The basis for all long-term success in restorative dentistry is a comprehensive diagnosis and treatment plan. The ability to preview a case from start to finish, communicate and co-diagnose with other specialists and specialists about dental patients via the virtual world is the true power and capability of digital dentistry.

The primary decision becomes where the handoff from one partner to another should occur. The dentist, who has the ability to optically scan teeth for impression making and chooses CAD/CAM restorations as the best treatment option for his or her patients, has enhanced freedom as to where the hand-off to the technician should occur. As a result, the laboratory is no longer a place, it is rather a great, virtual, workroom.

Communication is key The ability to facilitate communication between the dentist and the lab is of utmost importance and what makes the E4D system stand out. Tools such as the E4D Sky network enable E4D clinical operators to communicate and facilitate the transfer of data to technicians whenever laboratory involvement is required. With just a click, the entire case (whether scanned or completely designed) can be sent from the chairside to the laboratory for fulfillment of 4D dental professionals with basic knowledge of dental anatomy and occlusion to make modifications to the design, and then sends it through to the automated milling unit.

For the dental lab profession, the introduction of digital technology effectively automated or even eliminated some of the more mechanical and labor-intensive procedures (waxing, investing, burnout, casting, and/or pressing) involved in the conventional fabrication of a dental restoration, allowing the dentist and technician the ability to create functional dental restorations with a consistent, precise method. Linear versus vertical machining The successful laboratory of the future will need to focus not just on the quality of the end product, but also more efficient production methods to reduce turnaround time within the laboratory process. Digital technology will allow the laboratory
Sirona Group receives another Top Employer Award

Fig. 1: Sirona China is delighted to receive the Top Employer China 2014 award and together with the other 40 winners, it’s difficult to tell who is the happiest.

By Sirona

SALZBURG, Austria: Since receiving the Top Employer Awards for Germany, Austria and Engineers in 2015, Sirona’s excellent human resources policy and very good working conditions have also earned it international recognition in 2014. In an award ceremony in Shanghai, Sirona China was given the “Top Employer China 2014” award in mid-January. The company’s German employees have also been successful at the Chinese site.

In a multi-phase analysis and auditing process, the Top Employer Institute (formerly CRF Institute) designates outstanding employers around the world every year. Some of the key criteria include excellent working conditions, promoting talent, and continuous development of human resources management. Sirona China was given the highest award “Top Employer China 2014” along with 40 other employers. Michael Elling, Vice President Corporate Human Resources of the Sirona Group, expressed his satisfaction: “Our employees are the heart of our company. The Top Employer Award for Sirona China is an acknowledgment of our local and global efforts to support our employees. It is part of our global growth strategy, it increases our attractiveness as employers, and it motivates our employees to work at Sirona in Germany and abroad.”

Growth and development at Sirona China

In 2006, Sirona began to develop the business in China with just 30 employees. Today, eight years later, there are more than 150 employees here – a success story, also with respect to personnel development. “Employee satisfaction is the basis of our success at Sirona China. This is why we find it important to have an excellent team, promote team spirit, and motivate continuing development among our employees. It is rewarding to see how many employees successfully climb the career ladder,” explains Henning Müller, Vice President China and South East Asia. A strong growth that is reflected in the market. Sirona China is the number one company for dental treatment chairs. Digital dentistry and CAD/CAM products have also made significant gains in the past two years.

Employee success stories

Sirona offers many opportunities and promotes young talent among students as well. For example, the German student Verena Schütter spent four months at Sirona in Asia during her International Business studies at Baden-Württemberg Cooperative State University. She became familiar with the international company and the Shanghai location, and she helped develop the Singapore production plant that was opened in November 2015. A career opportunity open to all employees at Sirona fostered by the Talent Excellence Program encompasses individual advanced training, project assignments across positions and locations, and targeted international assignments and career advancement in one of its worldwide subsidiaries.

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The software has an Order Manager page that brings efficiency to the workflow by reporting the stage of each work. In this way, several work orders can be entered in the software in one go. The last phase is always saved in memory so working can be continued freely at the most suitable time. In addition, precise values can be set to each work for the cement gap and milling unit’s blade.

An ideal solution also for laboratories

For dental laboratories, Planmeca offers a comprehensive solution utilising the open STL file format. Planmeca PlanScan® Lab scanner is an accurate desktop scanner utilising blue light for scanning gypsum models and impressions. The device scans gypsum models fast and efficiently with an accuracy of 15 micrometres. Designing takes place in the open Planmeca PlanCAD® Premium laboratory software, which can be used for the design of all prosthetic pieces, ranging from one-tooth units to full-arch structures. The software can also be used to design individual abutments, implant bridges and bars for cemented and screwed solutions.

Designing begins with defining the margin line, after which the path of insertion is selected and the structure designed. Several automatic functions assist in the design work, and as the design progresses, the software shows the contact areas, material thickness and distance to the antagonist or adjacent tooth. A diagnostic wax-up made in the laboratory or anatomic models saved in the software can be utilised in the design work.

An open STL file is created as a result of the design work, and it can be manufactured with all milling units supporting the open file format, including the Planmeca PlanMill® 50. This milling unit can be used for the milling of all most common materials, excluding metals. In addition, the open file can be sent to a milling centre for manufacturing, such as Planmill’s own PlanEasyMill™ milling centre.
So saliva collected at a constant flow rate for 2 minutes will have a different composition from saliva collected at the same flow rate for 10-15 minutes.

Nature of the stimulus – Different stimuli have an effect on salivary composition, mainly because of their effect on the rate of flow. Acid is mainly because of their effect on salivary composition, -

Different stimuli have an effect on salivary composition, which results in an increase in pH. At very low flow rates, the pH of parotid saliva can be as low as 5.5, rising to 7.8 at very high flow rates. Individuals with hyposalivation will thus have a low salivary pH and a low salivary buffering capacity because of the low bicarbonate concentration.

Conclusion

Saliva not only plays a pivotal role in the maintenance of a healthy homeostatic condition in the oral cavity, but contributes to one’s overall health and wellbeing. Components from saliva interact in different ways with the dentition to protect the teeth. Patients who lack sufficient saliva suffer from many oral diseases, of which caries is only one. To alleviate discomfort they are advised to use saliva stimulants and substitutes which have the function of lubricating the oral surfaces. Chewing gum is increasingly being viewed as a delivery system for active agents that could potentially provide direct oral care benefits, as it promotes a strong flow of stimulated saliva.


*Underwriting costs for this Saliva and Oral Health edition were provided by Dr. Michael Dodds and The Wrigley Company.

References

Biological and conservative root canal instrumentation with BT-Race file system

Fig. 1: Median canal diameters.

Fig. 2: Benefits of Race files.

Fig. 3: BT-Race sequence.

Fig. 4: Efficiency of the normal tip and the BT in the canal: the path of the tip, with a guide.

Fig. 5: The BT and normal tip: localization of the cutting point.

Fig. 6: BT-Race XL for finishes at sizes 40 and 50.

By Drs Gilberto Dehedian & Martin Trope

Root canal instrumentation is one of the major tools for ensuring the long-term success of root canal therapy. The aim is to mechanically disrupt as much biofilm as possible so that with the addition of irrigants and/or intra-canal medicaments a very low microbial count can consistently be achieved before the filling of the root canal. Another aim or challenge of root canal instrumentation is to achieve the microbial reduction goals mentioned above without unnecessarily weakening the root by over-instrumentation, for example through the reduction of the dentinal wall thickness. Preservation of native structure, especially in the cervical region of the tooth has been demonstrated to correspond to better long-term survivability from a loading and restorative standpoint. It is well established that as the remaining dentine thickness decreases so does the root’s resistance to fracture.1

In evaluating anatomical studies, it is striking that they are consistent. Figure 1 best summarises the anatomical aims for a mandibular molar. The mesiobuccal and mesiolingual canals are at the 1mm measurement from the apical foramen, which corresponds most closely to the dentocemental junction. In the mesiodistal direction, the diameters are 0.21 and 0.28mm respectively, thus finishing at a 25° taper.2,3

The Booster Tip (BT; Fig. 3) is a non-screw-in design and triangular cross-section to increase cutting efficiency. It is also electropolished to decrease the effects of torsional and cyclic fatigue (Fig. 2).

By over-instrumentation, for example through the reduction of the dentinal wall thickness, preservation of native structure, especially in the cervical region of the tooth, has been demonstrated to correspond to better long-term survivability. From a loading and restorative standpoint, it is well established that as the remaining dentine thickness decreases so does the root’s resistance to fracture. However, when we look in the buccolingual direction, the correct file sizes are between 35 and 40. For the distal canal, a size 35 would appear adequate on the radiograph (mesiodistal view) but the correct size would be 50.

In order to achieve the goals mentioned above, we should aim for 35, 40 or 50 apical sizes with no more than a 0.04 taper. These biological sizes with the addition of an adequate irrigation protocol will ensure a consistently low microbial count for maximal success.

BT-Race system

BT-Race files (FKG Dentaire) are sterilised in individual blisters so that sterility is maintained for every file. The biological sizes mentioned above can be achieved with three files every time once a glide path has been established. The system was designed in such a way that these sizes are attained with minimal removal of dentine coronally to maintain the strength of the root. Moreover, the Race file has a non-screw-in design and triangular cross-section to increase flexibility and cutting efficiency. It is also electropolished to decrease the effects of torsional and cyclic fatigue (Fig. 2).

The Booster Tip (BT, Fig. 5) is the key feature of these files however. It allows them to follow the key feature of these files mentioned above without unnecesarily weakening the root by over-instrumentation, for example through the reduction of the dentinal wall thickness. Preservation of native structure, especially in the cervical region of the tooth has been demonstrated to correspond to better long-term survivability from a loading and restorative standpoint. It is well established that as the remaining dentine thickness decreases so does the root’s resistance to fracture. However, when we look in the buccolingual direction, the correct file sizes are between 35 and 40. For the distal canal, a size 35 would appear adequate on the radiograph (mesiodistal view) but the correct size would be 50.

In order to achieve the goals mentioned above, we should aim for 35, 40 or 50 apical sizes with no more than a 0.04 taper. These biological sizes with the addition of an adequate irrigation protocol will ensure a consistently low microbial count for maximal success.
The BT starts as a non-cutting tip from 0–0.15mm diameter and the cutting edges start from 0.15mm and upwards on the file (Fig. 4). Essential steps for the successful use of the BT-Race sequence are the following:

Glide path
In order to guarantee a minimal number of file breakages, a glide path to size 15.02 is essential. Hand files can usually achieve this aim. However, if a 6 or 10 file is extremely difficult to take to working length, ScoutRace files allow one to achieve this requirement more quickly.

Speed of 800–1,000 rpm
A high speed reduces the risk of breakage due to torsional fatigue, as these files are for use with individual patients only, the possibility of breakage from cyclic fatigue is also reduced.

BT1 (10.06 file)
This file (Fig. 5) establishes the final glide path and determines the canal diameter. In any canal in which a 15.02 glide path has been established, the file will contact the coronal third of the canal. At 12mm from the working length, the diameter will be 0.82mm. These files have no BT, since the tip diameter is already 0.10mm and smaller than the glide path established with a 15.02 K-file.

BT2 (parallel 55 file with BT)
The BT2 file (Fig. 5) is used to prepare the apical third of the canal. It is extremely flexible owing to its non-tapered design, yet penetrates into the narrow canal easily and efficiently with the BT.

BT3 (55.04 file with BT)
Fig. 7: Clinical case. (Courtesy: Dr. Gilberto Debelian, Norway)

This file (Fig. 5) is used to join the coronal and apical preparations created by the BT1 and BT2 files and thus create a 55.04 final shape that allows maximal irrigation and a tight cone fit. The file is able to go to working length with minimal stress, since the coronal third has been cleared with the BT1 file and the apical third with the BT2 file. Importantly in this canal, the maximum diameter at the 12 mm level is 0.85 mm. Consequently, the removal of coronal dentine is minimal, allowing for the strongest root possible after restoration.

BT-Race xL: BT 40 (40.04 file) and BT 50 (50.04 file), 600–800 rpm
These two instruments (Fig. 6) enable finishes at ISO 40 and 50 when adequate apical sizes require larger sizes. If even larger apical preparations than ISO 50 are required, the Race range of instruments is recommended in the required sizes, preferably with a small taper of 0.02. With this unique file system, all canals can be conservatively instrumented to the correct biological sizes while maintaining maximal cervical tooth structure.

The BT ensures that the original canal shape is maintained, thus keeping even the larger files centred in the canal. Through this advantage, in addition to the minimal taper required to achieve these biological sizes, the canal is maximally cleaned without weakening or stressing the root.

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KaVo Dental GmbH: Success at AEEDC

By KAVO

Dubai, UAE: For 5 consecutive days, KaVo Dental GmbH MEA took part in the 18th Edition of AEEDC Dubai 2014. We displayed a brand new Patient simulator for Universities that will be launched in spring 2014 as well as the complete range of ESTETICA treatment units. Guests were also invited to gain valuable hands-on experience with the new Leica M520 microscope with full HD integrated camera with Mrs. Natalia Lebedeva, Commercial Manager for Leica Microscopes.

And to further demonstrate the high tech product range of KaVo, the CAD/CAM systems, Arctica and Everest were also showcased by our product manager, Mr. Mohammad Abdallah, KaVo Dental GmbH Middle East & Africa.

We also hosted several exciting lectures with Dr. Heinz-Theo Laebbers, head of the Dental Radiology Dpt. of the University of Zurich, who enlightened us about CBCT technology. As part of our dental imaging portfolio, we showcased the Gendex GXDP-700 3D machine with Pan + Ceph, Pan + 3D, and Pan + Ceph + 3D, options that make it suitable for any dental imaging purpose.

In addition, Dr. Thorsten Wegner from Germany introduced the DIAGNOCam for modern carries detection without X-ray, which has recently received an innovation award from the German magazine “ZahnarztWoche” and Pluradent. The stand attracted the attention of a diverse crowd of professionals in the dental industry and it was a pleasure for us to meet all of them.

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The stand attracted the attention of a diverse crowd of professionals in the dental industry and it was a pleasure for us to meet all of them.

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