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From IDS Cologne to DUBAI: High Tech...

...Innovations in Dentistry at 10th CAD/CAM & Digital Dentistry International Conference, Jumeirah Beach Hotel Dubai, 08-09 May 2015

By Centre For Advanced Professional Practices

C OLOGNE, Germany / DUBAI, UAE: The 56th International Dental Show (10-14 March 2015) surpassed its predecessors with a record number of dental companies exhibiting in 2015 and over 125,000 dental professionals expected to attend the world’s largest dental showcase. Those who missed the opportunity to travel to Cologne, do not fear, the latest news and technological advances will be showcased in Dubai, in May 2015. For the tenth consecutive time, organized by Centre For Advanced Professional Practices (CAPP) and Emirates Dental Society, 10th CAD/CAM & Digital Dentistry Int’l Conference (a part of Dubai Dental Meetings) will take place at the remarkable Jumeirah Beach Hotel between 06 – 10 May 2015.

“Do you provide CEREC restorations in your office? Does this office use Zirconia and eMax for crowns and veneers? Doctor, are you into CAD/CAM technology? These are quite common questions the patients usually ask nowadays. Questions which are very hard to answer unless dental professionals are really involved in this fast moving technology. This is precisely the importance of such conferences. Our societies are becoming more and more dependent on technology and what it can offer to make our lives easier and more enjoyable. Dentistry is no exception. Our patients are all the way different than they used to be a couple of decades ago. They have unrestricted easy access to knowledge through the web. They are becoming more and more demanding in terms of services that we provide as well as the technology we employ to do so. Our team of Organizers, Sponsors, as well as Speakers will continue the quest to keep all of you well ahead and updated in all fields of CAD/CAM and Digital Dentistry.” – Dr. Munir Silwadi, Conference Chairman & Scientific Program Advisor comments on the lead up of an anniversary year in Digital Dentistry for the Middle East dental professionals.

This year’s CAD/CAM & Digital Dentistry Scientific Program is set to be arguably the most advanced of the series in its rich ten year history. Over 28 International Key Opinion Leaders are expected to walk and talk on the podium including Prof. Daniel Wismeijer (ACTA Amsterdam - The Netherlands), Prof. Paul Tipton (U.K), Prof. Richard Simonsen (USA), Dr. Andrea Gandolfi (Italy), Dr. Jan-Frederik Güth (Germany), Dr. Eduardo Mahn (Chile), Dr. Morten Worsøe, (Denmark), Dr. Harald Hiskens (German), MUDr. Petr Hajný, (Czech Republic) and lots more. Topics presented will vary from Ethics of Elective Dental Treatments,

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King of Sweden introduced to new standard of dental technology at Planmeca

By Dental Tribune International

HELSINKI, Finland: The Royal Technology Mission, with His Majesty King Carl XVI Gustaf of Sweden as its patron, visited Finnish health care technology manufacturer Planmeca in Helsinki on 27 November. His Majesty, along with 50 other top representatives of Sweden’s government, private sector and academia, learnt about the company’s growth story and innovations.

The Royal Technology Mission visited Finland to gain inspiration from the country’s innovative companies, initiatives and growth strategies. At Planmeca, the mission was introduced to revolutionary 3x3D technology, patient-specific 3-D implants, and the dental unit-integrated intra-oral scanner Planmeca PlanScan. Planmeca is one of the

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Sirona – The Dental Company shines in Dubai

By Sirona

Dubai, UAE: Sirona Middle East was again at the center of attention at the 19th International Dental Conference & Arab Dental Exhibition in Dubai between 17-19th February 2015. The Dental Company exhibited with a specially designed booth conducting ongoing trainings and presentations given by Sirona staff, CEREC trainers and Key Opinion Leaders including the infamous Dr. Daniel Vasquez, USA. Dr. Vasquez also presented at last year’s CEREC Desert Fest in Dubai.

Sirona will soon enter a new milestone in the Middle East region where a direct operation and dedicated dealership will work together to bring the sales and services of The Dental Company to a higher level compared to the rest in the industry. We presented the model to our customers during the International Dental Conference & Arab Dental Exhibition in Dubai and we expect a market service boost in the years to come.

After the successful CEREC Desert Fest in September last year we brought back Dr. Daniel Vasquez (USA) who is an icon in presenting CEREC to new customers. With his unique appeal in detailing the product to audiences Dr. Daniel provided several hands-on presentations at the trade show in front of interested potential and existing customers. The presentations showed the ease of using CEREC and how it is the CAD/CAM application which should be used in dentistry for the present and future.

Recently Sirona launched yet again a new system, providing freedom of choice with the MCX5. The new InLab system will have a big impact on the CAD/CAM lab business. The product was officially launched in the Middle East in February and the feedback was above expectations. The smart compact designed five-axis milling and grinding unit is especially developed for the demands of the dental laboratories completing Sirona’s InLab system. Dental Technicians will now benefit from the great flexibility for the entire production process of esthetically pleasing restorations and the largest selection of materials available on the market.

IDS Cologne 2015 – the Mondial of the Dental Industry is set to begin on 10th March and Sirona will bring all the new products to the market boosting the industry with different product lines such as Imaging and CAD/CAM systems, Treatment Centers and Instruments.

Sirona will continue to grow worldwide and in the Middle East region which will be shown through our core built on Education in our products which we produce for the dental industry. We are in a sector of our society that has built careers on knowledge and product understanding in order to deliver the best treatment to their patients. Sirona aims to always be in the background of our customers and supply them not only with the technology but the know-how behind the fast changing industry. This has been and will continue to be achieved through well maintained high level continuing dental education programs ensuring the long term continuity of our customers’ business.

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Immediate implantation and provisionalization: Single-tooth restoration in the esthetic zone

By Susan McMahon, DMD and Karrah Petruska

Anterior tooth loss and restoration in the esthetic zone is a common challenge in dentistry today. The prominent visibility of the area can be especially distressing to the patient and requires a timely and esthetically pleasing solution.

Immediate single-tooth implantation followed by immediate provisionalization is becoming an increasingly desirable treatment option. This method offers numerous benefits over conventional delayed loading.

In the past, the non-restorative tooth was extracted and possibly grafted for site preservation. A removable partial denture (flipper) was fabricated and placed for use during healing. After an adequate healing period, an implant was placed and buried under the gingiva, and the patient continued to wear the flipper until the implant had osseointegrated and was ready to be uncovered and restored. The patient would therefore wear the removable partial denture for upwards of six to eight months.

This course of treatment often resulted in an unnatural gingival architecture surrounding the final restoration. There are also clear indications that partial removable dentures are an important causative factor in the alveolar bone resorption process. Today, immediate treatment offers a better solution. Immediate implantation and same-day provisional restoration of single anterior teeth minimizes treatment time and cost while enhancing esthetic quality. In addition to alleviating patient trauma, this technique decreases resorption of hard and soft tissue and results in better function. Overall, this leads to greater patient satisfaction.

In this process, the implant is placed and provisionalized quickly and loaded. A nonfunctioning, also known as non-occluding provisional is used in a protected occlusal scheme. The placement of the non-occluding restoration must occur within 48 hours to be considered immediate loading. Both of the following cases received same day provisionalization.

The clinician faces several challenges when restoring teeth in the esthetic zone. Major cosmetic concerns in the fabrication of the immediately placed provisional are the retention of the interdental papilla and prevention of alveolar bone collapse. Research has suggested that immediate provisionalization following implantation allows for greater clinical control over the regeneration of tissue surrounding the site of extraction. Unfavorable alterations to the alveolar bone structure must be avoided using ridge preservation techniques and precautions in terms of osseous exposure.

Immediate placement of the implant into fresh extraction sockets prevents the post-extraction resorption that occurs commonly with alternate forms of treatment, preserving the integrity of the alveolar ridge. A compromised implantation site is also a concern when tooth loss. Bone resorption may leave insufficient bone for implantation. Furthermore, a deproteinized and dehydrothermalized architecure produces an inferior esthetic. Immediate implantation into the fresh extraction socket allows the clinician to maintain the gingival tissue and create a more esthetically pleasing restoration.

Minimum criteria for implant placement have been established for successful immediate loading. Rough quantitative values for insertion torque and implant stability quotient (ISQ) as well as surgical assessment play a role. Values as low as 15 N cm for insertion torque and 50 ISQ both resulted in successful provisionalization. Additionally, the surgeon must assess where there is adequate bone support at the apex, at least 5 mm of circumferential bone, and primary stability of the implant. Research has shown that “early loading of dental implants does not appear to interfere with osseous modeling of a developing osseointegration as long as significant micromovement does not occur.” However, in addition to providing both esthetic and functional benefits, immediate implantation and loading of a nonfunctioning provisional has also been found to result in comparable implant survival outcomes to more traditional techniques. A recent study measuring clinical success, survival, and satisfaction found the immediate implant “not less favorable than conventional loading.” In consideration of this, current literature is now purporting immediate implantation and non-occlusal loading to be the “treatment of choice” in cases of single anterior tooth restoration.

The following are two case studies involving immediate provisionalization. In both cases, the maxillary right central incisors had sustained trauma, were endodontically treated and functioned for a number of years. Approximately 15-20 years later, the teeth in each case failed due to internal resorption. The failing teeth were extracted and implants were inserted immediately and restored the same day with a non-functional provisional.

Dental root resorption involves the loss of hard tissues that compose the teeth (dentin, cementum and enamel). In most cases, tooth resorption is the result of trauma or irritation to the periodontal ligament and/or tooth pulp. These conditions may occur as a result of injury, inflammation or chronic infection of the pulp, periodontal disease, or root canal therapy. If internal resorption is generally asymptomatic and is discovered most frequently through radiographic examination. If internal root resorption is left to progress untreated, it may result in conditions detrimental to the interarch architecture. The plastic coping for the immediate provisional crown was fabricated to non-functional to ensure the integrity provisional material used. The provisional was polished and placed on the immediate temporary abutment with a small amount of flowable composite to enhance retention. The provisional crown was fabricated to be completely out of occlusion and non-functional to ensure the implant adequate osseointegration time undisturbed by occlusal forces. The provisional restoration was observed periodically during the six-month healing process to monitor gingival adaptation.

Final restoration Six months post surgery, the patient was scheduled for placement of the final restoration. After removing the provisional crown and the immediate temporary abutment, an implant impression post was placed, radiographic verification was made to assure complete seating and a final impression was taken with a polyether system. Complex shade-mapping was carefully performed to match the existing contralateral natural color. The fixture received an emergence profile, healing abutment.

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Fig. 1

Fig. 2

Fig. 3

Fig. 4

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teeth. The provisional was then reinserted. A Procera zirconia custom implant abutment was chosen. Zirconium implant abutments have not only been noted for their tooth-like color and esthetic appearance but also their biological, high load strength and inconspicuous design enhancement.

The extraordinary load strength of the abutment is not compromised by high bending and tensile strength, and fracture and chemical resistance.

Zirconium abutments are mechanically equivalent to their metal counterparts but boast greater biological compatibility.

Results of a recent study provide evidence that the ceramic oxide abutments can be safely utilized in the incisor region of both the maxilla and mandible as determined by maximal bite forces in the esthetic zone. Due to excellent restorative properties in terms of strength and color conformity, the zirconium implant-abutment is becoming increasingly favored by clinicians for esthetically pleasing anterior implant restorations. A Procera zirconia crown was fabricated for this patient with Noritake CZR porcelain (Fig. 5).

At the time of the insert, the provisional crown and immediate temporary abutment were removed. The Procera crown and custom abutment was seated, the screw was hand tightened and the screw was torqued to 55 Ncm with the manual torque wrench. The access was filled with a small cotton pellet and topped with a thin layer of flowable composite.

The Procera zirconia crown was then seated; margins, contacts and occlusion were confirmed; and the crown was cemented in place with 3M ESPE Rely X luting cement (Fig. 4).

Case study 2: Fractured maxillary right central incisor

This patient, a healthy male in his late 30s, was examined in my office for the maxillary right central incisor. The patient had Feldspathic porcelain restorations on his upper central and upper lateral incisors that were placed several years ago. He had a history of trauma to the anterior teeth from a sports injury and subsequent endodontic treatment. Recent periapical radiographs showed internal resorption in the upper incisors (Fig. 5). The patient sustained additional trauma to the maxillary right central incisor through a fall, which resulted in complete fracture of the crown (Fig. 6). The tooth was nonrestorable after reviewing the different treatment options, the patient decided on a zirconia provisional implant restoration. Although the maxillary left central incisor also exhibited signs of internal resorption, it was decided that treatment of that tooth would be performed at a later date. Consideration was given to the poor gingival architecture that results from placing adjacent implants in the esthetic zone. He was then evaluated by the periodontist for the surgical placement of the immediate implant for the maxillary right central incisor. The patient’s treatment was similar to that of the patient in the provisional. Immediate placement and restoration of a single implant offers a highly esthetic and timely treatment option in the case of internal resorption and tooth failure in the maxillary central incisors.

Furthermore, this treatment eliminates the need for a removable partial denture while maintaining the gingival architecture and preventing alveolar bone loss in the extraction site. As aesthetic expectations of patients and the desire for a convenient and timely treatment continue to increase, instantaneous replacement of failing teeth is becoming more routine.

Not only does placing the implant immediately following extraction maintain the alveolar architecture and retain the interproximal papillas, placing the provisional immediately thereafter refines the level of treatment the clinician can offer the patient. Esthetic quality is enhanced without comprising long-term implant stability. Immediately placing and loading implants is both functionally and cosmetically beneficial.

References


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About the Authors

Susan McDaniel, DDS, is in private practice in Pittsburgh. She is accredited by the American Academy of Cosmetic Dentistry and is a sixth-time award winner in the LACD Academy Awards. She has served as a clinical professor in prosthodontics and operative dentistry at the University of Pittsburgh School of Dental Medicine, and is an immediatodontist at West Virginia School of Dentistry and lectures to dentists in Canada, the United States, and Europe. You can contact McDaniel at www.wowinsmile.com.

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The Nr. 1 recommendation¹ from dentists is to use floss, so why aren’t more people doing so?

By Jordan

Most of us have been told by our dentist that we should clean better between our teeth. Floss is a great tool to do just this. Flossing should be an essential part of any oral health care routine. Most national Dental Associations, including the American Dental Association, recommends flossing at least once a day to achieve optimal oral health.

So why is it so important? We all want clean and healthy teeth. To get this we need to invest time each day to “brush” properly. Our teeth have 5 surfaces and only 3 of them are properly cleaned by a toothbrush. In order to remove plaque from between our teeth we need to use an interdental product. If we do not remove plaque regularly it will harden and could lead to a cavity and tartar. The area just under where two of our teeth meet is one of the most susceptible to cavities. Areas in our mouth which are difficult to get to, for example around our back molars and at the back of our teeth, also make them targets for plaque build-up and tartar.

In Scandinavia, dentists recommend that children start using floss as early as when their permanent teeth start to emerge, in other words before they are 10 years old. The American dental Association recommends that children start to floss when two teeth of their teeth touch. Parental help is advised as it is difficult for children to master the technique. Establishing this habit early and doing so on a daily basis is the best way to keep your teeth clean and your gums healthy. Flossing can also help prevent and reverse the early stage of gum disease, gingivitis.

So why aren’t more people flossing? In our research¹ the three most important reasons that we came across were:
- A lot of people don’t floss because they don’t think they need to. “I have no cavities or gum disease”
- It’s a routine that is difficult to establish daily. “I don’t see the results”; “it’s boring”; “it takes too long”
- It’s not easy finding the right products. “There are a lot of choices, I don’t know which ones is right for my needs”; “I don’t like having my hands in my mouth and it’s difficult to use”

A bad past experience stops continued use. “I don’t like that my floss shreds”; “My teeth are too tight”

Jordan has a range of quality products designed for different consumers’ needs and lifestyles. Traditional floss is very effective but for some people it can be difficult to master the technique. Research shows if you are a traditional floss user, you are loyal to this format because you feel it is the most effective. Flossers are easy and convenient to use and we see more and more people choosing this as an alternative and sticking to it. This seems to be a good tool to recruit new users.

The Nr. 1 reason why people start to use floss is still because their dentist recommended it. So keep recommending and help them find the best floss product for them.
Myths vs. Truths

By Beverly Hills Formula

There are many misunderstandings surrounding whitening toothpastes. We tackle the common patient misconceptions to help you confidently recommend the most suitable choice for your patients.

Although teeth whitening has become one of the most sought after cosmetic dental treatments requested by patients, not all will want to “splash their cash” on these expensive treatments, but, by the same token, they are also dubious about whitening toothpastes:

1) “Whitening toothpastes are ineffective”

In late 2012, whitening toothpaste came under scrutiny when ARM & HAMMER’s Advanced Whitening toothpaste advertisements were banned after it emerged that 45 per cent of users, during a four-week trial, either saw no improvement or were left with darker teeth (1). By association, many patients assume that all whitening toothpastes do not live up to their claims.

Contrary to this, it’s important that the effective toothpastes available, which are clinically proven to work, are brought to your patients’ attention. These products should contain ingredients such as the stain-dissolving agent, Pentasodium Triphosphate and anti-tartar ingredient, Tetrasodium Pyrophosphate.

Pentasodium Triphosphate can remove deep surface stains as part of a daily oral care regime to brighten, lighten and whiten teeth. It also prevents food particles settling on the teeth, effectively keeping teeth whiter for longer. For extra stain removal, Tetrasodium Pyrophosphate coats the surface of the teeth to prevent bacteria forming, leaving teeth feeling and appearing brighter all day.

2) “Whitening toothpastes use harsh abrasives to remove stains”

There is a misconception that to remove dental stains caused by smoking and some foods and drinks, patients need to resort to products that contain harsh abrasives. This is not the case.

Recommended patients use whitening toothpastes that contain Hydrated Silica. This low abrasive polishing ingredient, which is frequently combined with the softer calcium carbonate to provide a smooth gel-like quality, works hard to remove plaque and stains and whiten the teeth. It has no distinctive taste or odor and may also be labelled as amorphous silicon dioxide, silicic acid, or silica gel. This mild abrasive is harmless and is even listed by the US Food and Drug Administrative as “Generally Recognised as Safe”.

5) “I suffer from sensitivity so whitening toothpastes are not for me”

Teeth sensitivity is a common dental problem and there are many brands of toothpastes that claim to treat sensitivity. However, recommend patients to use toothpaste that contains Potassium Nitrate. This desensitising agent relieves tooth sensitivity by effectively blocking the transmission of pain sensation between the nerve cells that enable cold and hot sensations to reach the tooth’s nerves. There are toothpastes available that combine Hydrated Silica for high performance whitening and Potassium Nitrate for rapid sensitivity action.

4) “I tend to suffer from bad breath occasionally so whitening toothpaste wouldn’t be my main concern”

Bad breath is a very common concern and can impact on self-confidence, image and health. Many enjoyable foods and beverages, for example onions, garlic and coffee can cause bad breath affecting ones day to day routine. Activated charcoal has the ability to remove impurities and bacteria and toothpaste containing this ingredient can benefit your patients’ daily confidence and over all oral health. Patients can use a small amount of charcoal, the recommendation of this ingredient, an old wives’ cure, can help safely eliminate odour causing bacteria whilst maintaining the mouths natural balance. In addition to this, charcoal is known to remove impurities whilst safely dissolving stains.

Addressing concerns

Beverly Hills Formula offers an entire range of products to address all these patient concerns.

Low in abrasion, Perfect White toothpaste contains Hydrated Silica; stain dissolving agent, Pentasodium Triphosphate; and anti-tartar ingredient, Tetrasodium Pyrophosphate. For extra stain removal, this toothpaste can be left on the teeth for up to one minute before brushing.

And for patients who suffer from sensitivity, but long for that gleaming Hollywood Smile, Perfect White Sensitive is the toothpaste of choice. It contains desensitising agent, Potassium Nitrate.

Boasting an innovative formulation, Perfect White Black contains activated charcoal along with the stain dissolving ingredients in Perfect White to provide a solution for patients looking to combat bad breath whilst also dissolving surface stains.

Ultimately, Beverly Hills Formula’s range of whitening toothpastes offers patients an affordable way to remove the natural whiteness of their teeth by removing stains from the tooth surface, whilst providing that all-important, long-lasting protection.

References

(1) The whitening toothpaste that can make teeth DARKER: Ad starring Blue Peter girl Katy Hill banned after customers say product didn’t work:

Contact Information

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The importance of cementation: A veneers case using a new universal cement

By Mitch A. Conditt, DDS

Introduction

Esthetic options in dentistry are the prevailing choice of most patients today. Veneers and bleaching in particular have become buzzwords in popular culture, and TV sitcoms, film and magazine advertising have turned these cosmetic techniques into household names.

As a result, dental teams must accommodate the demands of their patients, becoming highly versed in placing metal-free restorations.

Practitioners can find a multitude of educational articles and courses teaching the science and technology of porcelain, zirconia and composite. But while emphasis is frequently placed on the final prosthesis or direct restoration, often overlooked are the increasingly important auxiliary materials that contribute equally to the clinical success of these new materials and restorations: impression and provisional materials, bonding agents and cements. Education is imperative because cementation and bonding are two areas of esthetic dentistry that have evolved through generations of products and techniques.

These processes are essential in making esthetic restorations both functional and comfortable.

That's why veneering can be an optimal, conservative alternative to crowning teeth, since preservation of tooth structure is important to dentists and patients alike. The highly esthetic results are due to the fact that ceramics have a translucent finished surface texture similar to that of natural enamel.1 Dentists, assistants and lab technicians spend vast amounts of time and effort perfecting veneers and avoiding fracture through painstaking preparation, material and shade selection, fit and fabrication. Yet even after such arduous processes, clinical failure and patient dissatisfaction can readily occur with errors in cementation.

Cementing veneers is a delicate process with a historical litany of potential problems – color instability, insertion difficulty, handling and cleanup issues, unsatisfactory radiopacity, low translucency after curing, mismatch between try-in gels and final cements, and debonding, to name a few. Cement selection in certain applications necessitates knowledge of the chemistry and physical properties of the particular cement type, and insertion requires an exacting technique for successful clinical results.2

This article outlines a veneer case using NX3 Nexus® Third Generation—a new, universal cement from Kerr. The subject is a long-standing patient of record with a current radiological and medical chart. This focus is on the steps and techniques implemented at final cementation of the prostheses.

Clinical Case

A female patient in her mid-fifties presented a chief complaint of being unhappy with her smile. An examination of her hard tissues revealed immediate concerns of multiple fractures, hypocalcification, shortened anterior teeth due to wear and an asymmetrical smile line (Figures 1 and 2).

After proposing a first phase treatment plan to restore all of her compromised upper anterior teeth, the patient consented to restoring only teeth numbers 6-11. The patient ultimately qualified for and accepted veneers as the mode of indirect restorative treatment.

Prior to preparation, the tissue around tooth No. 8 was recontoured. Then, the teeth were prepared for pressed ceramic veneers and provisionalized in the standard manner. Occlusal analysis and adjustments were performed over a period of weeks and the veneers were tried-in. After the requisite steps were completed preceding insertion and the veneers were finalized, the provisionals were removed and the teeth were cleaned (Figure 5).

Expasyl® was used for gingival retraction and hemostasis in order to gain cervical access and control bleeding in that area (Figure 4).

The teeth were then etched for 15 seconds with Kerr Gel Etchant, which is composed of 37.5% phosphoric acid (Figure 5), and then rinsed and slightly air-dried. (Note: While a total-etch technique was used, NX3 works with both total-etch and self-etch protocols, adding to the distinctiveness of the product.) Per manufacturer directions, OptiBond Solo Plus (kerr) was brushed onto to the tooth surfaces for 15 seconds (Figure 6), air-thinned for 5 seconds, and cured for 10 seconds using the L.E. Demetron B curing light (Kerr) (Figures 7 and 8).

After etching and bonding, the veneers were cemented using NX3 light-cure cement in the clear shade (Figure 9). The cement was dispensed directly onto the internal surface of the veneer and was expected to ooze from all margins when the veneers were placed onto the prepared teeth. With the choice of either the single-syringe light-cure cement or the universal cement from NX3 Nexus® Third Generation—a new, universal cement from Kerr. The subject is a long-standing patient-of-record with a current radiological and medical chart. This focus is on the steps and techniques implemented at final cementation of the prostheses.
cure veneer cement or the dual-syringe dual-cure resin, the light-cure method was used because the veneers were not inordinately thick. NX3 allows veneers to be cemented all at once (as opposed to cementing centrals first, laterals second, and so on) because of its unique “thixotropic” properties, which enable them to stay where they are placed prior to light-curing. This feature makes adjustments and proper placement easier while decreasing the need to adjust the veneers interproximally if space is needed once they are cured.

Prior to final curing, the restorations were spot-cured for several seconds to allow the excess cement to be cleaned (Figure 10). The veneers then were light-cured for 40 seconds per surface (Figure 11). (Note: Manufacturer instructions allow for 10-second cures with the L.E. Demetron II. In this case, however, the doctor’s discretionary use was 20-second cure times.) Occlusion was adjusted using a fine diamond bur and the lingual aspects of the teeth were finished and polished using CeraGlaze® Porcelain Polishing System (Axis Dental), rendering a very satisfied patient (Figures 12 and 13).

Conclusion
Cementation is an important aspect of functional aesthetics. An understanding of chemistry, technology and physical properties are all essential to proper usage and clinical success. Cement selection was the driving factor in choosing the bonding system for this case. NX3 Nexus® Third Generation cement is free of amines—organic compounds containing nitrogen as their key atoms—which were largely blamed for the colour shifts so prevalent with earlier cement formulations. In an earlier use of the product the cement proved to be “thixotropic,” the consistency of non-drip paint; the restorations were seated and adjusted before curing with no dripping or running. Color stability, ease-of-use and cleanup, color match and optimum retention are some of the attributes necessary when choosing a cement—NX3 met all of these expectations.

References

About the Author
Dr. Mitch Conditt, a 1985 graduate of Baylor College of Dentistry in Dallas, TX, lectures internationally and has published numerous articles reviewing all aspects of restorative and cosmetic dentistry.
Face asymmetries in children and adolescents – Classification and clinical characteristics

By Athanasios E. Athanasiou, D.D.S., M.S.D., Dr. Dent.

Introduction

Perfect bilateral body symmetry is more of a theoretic concept that seldom exists in living organisms. However, pronounced and recognizable face asymmetries do exist and can have serious esthetic, functional and psychological implications. Asymmetry in the craniofacial areas may be the result of discrepancies either in the form and/or size of individual bones as well as malposition of one or more bones in the craniofacial complex. The asymmetry may also be limited to the overlying soft tissues (1). Early detection of face asymmetry may be critical with regard to the diagnosis, prognosis, and therapeutic management. The aim of this article is to briefly present the major categories of face asymmetries in children and adolescents and to provide information on their clinical characteristics.

Etiology

Genetics have been implicated in certain conditions such as multiple neurofibromatosis (Figure 1), hemifacial microsomia, cleft lip and palate. Intrauterine pressure during pregnancy and significant pressure at the birth canal during parturition can have observable effects on the bone of the fetal skull. Environmental factors can cause face asymmetry and may include pathological changes that are not congenital in nature (e.g., osteochondromas of the mandibular condyle), trauma, infection and inflammation within the temporomandibular joint (TMJ), ankylosis of the mandibular condyle to the temporal bone, damage to a nerve, which may indirectly lead to asymmetry from the loss of muscle function and tone, and sucking or chewing habits with influence on tooth position equilibrium (1,2).

Classification

Skeletal Asymmetries

The skeletal asymmetries may involve one bone (e.g., maxilla or mandible) or a number of skeletal and muscular structures on one side of the face.

Hemifacial microsomia

Hemifacial microsomia results from the malformation of the 1st and 2nd branchial arches. It involves mostly unilateral condylar underdevelopment, it may be associated with variable abnormalities of the external and middle ear, has similar manifestations with Goldenhar syndrome, and its etiology is heterogeneous. The extent of TMJ involvement primarily determines severity, prognosis, timing and type of treatment. Face asymmetry in hemifacial microsomia is characterized by chin deviation. Occlusal manifestations include lower dental midline deviation, unilateral crossbite, tilting of the occlusal plane, all of them towards the affected side (Figure 2). Apart from ear abnormalities, soft tissue defects may include skin tags, facial clefts, cranial nerve function, soft palate function, bulk of subcutaneous soft tissue, muscles of mastication and facial expression, macrostomia, and skin tags (5).

Hemimandibular hyperplasia

Hemimandibular hyperplasia is an uncommon maxillofacial deformity characterized by increased ramus height, rotated facial appearance, and kinking at the mandibular symphysis. Usually it is associated with prominence of the lower border of the mandible, maxillary and mandibular alveolar bone overgrowth, compensatory canting of occlusal plane, and serious functional malocclusion (4) (Figure 3). Hemimandibular hyperplasia presents diffuse enlargement of the condyle, the condylar neck, the ramus, and the body of the mandible, it usually begins before puberty, is clearly due to hyperactivity in the condyle, whose cartilage actively proliferates.

Condylar fracture

Condylar fractures in growing individuals are usually the results of accidents and sports (Figure 4). In children they are often overlooked by parents and physicians since short time after the injury symptoms of pain usually disappear. The majority of condylar fractures in children, if properly diagnosed and man-
patients report limited mouth opening without any pain, the condition has been present for a long time, and, if not associated with severe dentofacial deformity, patients do not feel that it poses a significant problem.

Muscular and Soft Tissue Asymmetries
Facial disproportions could be the result of muscular and soft tissue asymmetry (e.g., hemifacial atrophy or cerebral palsy), muscle size disproportion in volume and/or toxicity (e.g., masseter hypertrophy, dermatomyositis (Figure 6), and neoplasms (Figure 7)). Abnormal muscle function often leads to skeletal deviations (2).

Conclusions
Face asymmetries in children and adolescents should be detected and diagnosed as early as possible. Early detection may be critical with regard to the prognostic and therapeutic management of this challenging dentofacial deformity.

References

Figure 6. A 10-year-old boy with dermatomyositis creating a soft tissue toxicity imbalance (a) and resulting in a unilateral posterior crossbite (b).

Figure 7. A 15-year-old girl with hemangioma “infrabulbare” (a) applying excessive pressure on the left maxillary teeth (b) and severely influencing their position (c).

TMJ ankylosis
It is a chronic hypomobility and, if happens in growing subjects, it becomes a growth disorder (Figure 5). It results from intracapsular adhesions or ossification between the disc and temporal articular surface that attach the disc-condyle complex to the articular eminence. Its classification relates to the degree of limitation (partial or complete), location of the union (intracapsular vs. extracapsular), and type of tissues involved (fibrous, osseous, fibro-osseous). TMJ ankylosis occurs relatively infrequently. Principle causes include trauma, previous joint surgery, systemic or local infections, tumors, compressive function pattern and systemic diseases (6). Regarding history,
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Clear fixed appliances chosen over aligner treatment for arch development

By Dr. Stuart Frost, USA

Pretreatment Diagnosis

Class I (end-to-end molar on right), female patient, 56, presented for clear aligner treatment. She had had orthodontic treatment years before. Given that her chief concerns were the crowding in her lower arch and widening her smile, I was able to convince her that passive self-ligation would offer her the results she wanted and could satisfy her need for esthetics since Damon Clear was then available in prototype. She had no jaw popping or clicking.

Facial/Soft Tissue/Macroesthetics: Mildly convex profile and nasolabial angle. Slightly lip strain at rest with lower midline shifted to the right.

Smile/Mini esthetics: Excessive upper gingival display, narrow arches with 5 to 4 mm of crowding in the lower arch and 1 to 2 mm of crowding in the upper arch. Consonant smile arc.

Teeth/Microesthetics: Esthetically-shaped teeth and excellent hygiene. Inconsistent gingival architecture in the lower anteriors and UR5.

Treatment Objectives and Plan

Treatment allows us to achieve esthetic fixed appliance needs, esthetic fixed appliance treatment can satisfy certain patient objectives. Widening the transverse arch width, especially U2-2, also diminished the excess gingival display.

What I Would Do Differently Today

The patient had a lateral tongue thrust at the UR5. Were I to treat the case today, I would place lingual tongue reminders on the UR5 that would likely have resulted in a more satisfactory Class I right cuspid relationship.

Damon Clear/DQ Variable Torques Employed

U1s: Standard torque (+15)
U2s: Standard torque (+6°)
U3s: Standard torque (+7°)
L1-2s: Low torque (+13°)
L3s: Super torque (+15°)
LR3: Standard torque (+7°)

Treatment Sequence

Bonding

U/L: Direct-bonded U/L arches, engaging 0.014 round Damon Optimal Force Copper Ni-Ti (Cu Ni-Ti) archwires. After 4 weeks, transitioned into 0.014 x 0.025 (upper) and 0.018 round (lower) Cu Ni-Ti archwires. Started shorty CL II elastics (bilaterally L6 to R6) and .018 round (lower) Cu Ni-Ti.

2 Months: Shorty CL II Elastics Maintained Throughout Treatment

U: Transitioned to a .019 x .025 TMA archwire with a step-up bend in the LR4. Maintained these archwires until debonding.

References

1. All Copper Ni-Ti wire used is Damon Optimal Force Copper Ni-Ti.

Contact details available from the publisher.
Dubai Healthcare City’s Medical University Announces New Identity of its First College - Hamdan Bin Mohammed College of Dental Medicine

By Dental Tribune MEA

Monday, February 16, 2015: Ahead of the 10th edition of the UAE International Dental Exhibition (ADDE), Dubai Healthcare City (DHCC), the world's largest healthcare free zone, today announced the new identity of the Hamdan Bin Mohammed College of Dental Medicine (HBMCDM), formerly the Dubai College of Dental Medicine.

Dubai, February 16, 2015: Ahead of the 10th edition of the UAE International Dental Conference and exhibition – AEEDC, Dubai Healthcare City (DHCC), the world’s largest healthcare free zone, today announced the new identity of the Hamdan Bin Mohammed College of Dental Medicine (HBMCDM), formerly the Dubai College of Dental Medicine. The college is under the patronage of His Highness Sheikh Hamdan Bin Mohammed Bin Rashid Al Maktoum, Crown Prince of Dubai.

The Hamdan Bin Mohammed College of Dental Medicine is the first college established under Dubai Healthcare City’s first medical university, the Hamdan Bin Rashid University of Medicine and Health Sciences (MBR-UHMS). It promotes an integrated learning environment through its Dubai Dental Clinic and through DHCC’s medical education entities under the Hamdan Bin Rashid Academic Medical Center (MBR-AMC).

“Education is a key pillar supporting our nation’s sustainable growth and knowledge-based economy,” said HE Dr Raja Al Gurg, Vice-Chairperson of Dubai Healthcare City Authority. “Medical education entities will help improve clinical performance and will, ultimately, drive excellence within the healthcare system.”

Dubai Healthcare City (DHCC), the world’s largest healthcare free zone, today announced its second college under the MBR-UHMS - the College of Dental Medicine.

The College offers six postgraduate programmes, accredited by the Ministry of Higher Education and Scientific Research (MOHESR) in collaboration with the UK-based Royal College of Surgeons of Edinburgh (RCSEd). As of January 2015, 60 residents were enrolled.

“The Hamdan Bin Mohammed College of Dental Medicine caters to international, GCC and UAE residents who seek specialization,” said Professor David Wray, Dean of the HBMCDM. “Through simulation training and access to world-class specialists, our residents graduate having mastered the most-cutting edge procedures in dental medicine.”

In January 2015, DHCC announced its second college under the MBR-UHMS - the College of Medicine. ■

Structured lifestyle helps prevent dental caries in children

By Dental Tribune MEA

LEIDEN, Netherlands: Dental caries is one of the most common chronic childhood diseases worldwide and can affect a child’s quality of life significantly. Several studies have identified a correlation between caries and lifestyle factors, such as physical activity and meal frequency. A team of researchers has now found that, especially for younger age groups, regularity and a structured lifestyle are very important for preventing caries.

The researchers at the Netherlands Organisation for Applied Scientific Research examined the impact of such factors on caries experience at different ages. They based their study on the data collected in a previous study on oral health in children and adolescents in the Netherlands that aimed to describe the oral health status and the preventive dental behaviours of 9-, 15- and 21-year-olds.

The researchers examined the frequency of toothbrushing per day, the frequency of having breakfast per week, and the frequency of food and drink consumption per day. The 21-year-olds examined in the study did not show significant differences in caries experience in relation to the lifestyle factors studied. For the 9- and 15-year-olds, however, the lifestyle factors had a significant effect on their dental caries experience.

For the two younger age groups, not having breakfast and not brushing their teeth twice a day were associated with a significantly higher caries experience. In addition, consuming food or drinks more than seven times a day resulted in an increased caries experience for the 9-year-olds.

The findings of the study demonstrate that components that promote structure and regularity in a child’s life, such as having breakfast and the frequency of food and drink consumption per day, are essential to prevent dental caries.

According to the researchers, it would be helpful to include these lifestyle factors in programmes to prevent dental caries in children and to communicate preventive messages about the consumption of food and drinks between different health and oral health professionals.

The study, titled “Impact of lifestyle factors on caries experience in three different age groups: 9, 15, and 21-year-olds,” was published in the February issue of the Community Dentistry and Oral Epidemiology journal.
Drill through the tooth technique for molar implant placement

By Dr. André C. Hattingh BChD, MDch cum laude, Specialist Periodontist & Dr. CostaNicoloopoulos BDS cum laude, FFD(GA), Oral & Maxillofacial Surgeon

The immediate placement of a “conventional” (4-6 millimeter diameter) dental implant into a molar extraction socket poses a number of difficulties. Most significantly is the size and shape of the multi-rooted molar socket. It is not suited for optimal placement of a typical dental implant and often results in compromised implant positioning, poor primary stability or the inability to place an implant at all. This may result in the need for a waiting period of 3 to 6 months, to allow for healing of the socket and bone formation prior to attempting implant placement.

This waiting period often ends in reduced bone volume (height and width), which is inadequate for implant placement and the resulting need for bone augmentation procedures, especially in the posterior maxilla. This necessitates longer treatment times with increased cost and complexity. An alternative approach has been to place a 5-6 millimeter diameter implant into one socket of a multi-rooted extraction site, typically the palatal socket of a maxillary molar. Problems associated with the latter approach include adverse biomechanical forces resulting from the implant being off-centre and off-axis to the application of load. Poor emergence profile and difficult plaque control also result from the unavoidable buccal overhang of the restoration.

The ability to place an implant immediately into a fresh molar extraction site embodies a major advantage in molar tooth replacement. This modality is however critically dependent on the preservation of the periodontal bony wall of the socket at extraction. In the case of a multi-rooted molar tooth, it is recommended not to attempt a conventional extraction, but to plan for the individual removal of roots in order to avoid potential fracture of the buccal plate. If the crown of the molar is cut off buccally (Fig.1), preparation of the osteotomy site can be initiated through the pulpal floor (Fig.2) and into the interradicular bony septum (Fig.5).

It is important to consider the periodontal biotype of the patient when applying this protocol. Medium to thick periodontal biotypes are the most suitable cases. Thin biotypes are contra-indicated in this treatment approach and it is recommended that “traditional delayed protocols” are followed for thin biotypes.

Preparation of a pilot hole through the pulpal floor (Fig.2) of a decoronised molar (Fig.1) should specifically be directed slightly toward the lingual aspect (Fig.5) in the case of a mandibular molar and slightly and toward the mesial aspect (Fig.6) in the case of a maxillary molar. Maxillary molars often have more space available on their mesial aspects (between the first molar and the second premolar) than on their distal aspects (between the first and second molars – Fig.4).

It is of the utmost importance that these initial preparation guidelines are followed in order to ensure that the final osteotomy preparation is away from the buccal wall (in the case of a mandibular molar where the bucco-lingual dimensions are critical) and away from the mesio-buccal root of the maxillary second molar (in the case of an upper first molar replacement). The aim is to initiate preparation in the following positions:

- Mandibular first molar (Fig.5)
- Maxillary first molar (Fig.6)
- Mandibular second molar (Fig.7)
- Maxillary second molar (Fig.8)
- Mandibular third molar (Fig.9)
- Maxillary third molar (Fig.10)

The roots can then be sectioned and carefully removed taking care NOT to remove any bone in the process (Fig.7a). It is essential to then inspect the socket walls and to ensure that all 4 walls are present and intact. If any of the required 4 walls are absent or significantly damaged, immediate implant placement becomes contra-indicated and a delayed protocol is then advised. Once the roots are removed, further preparation of the socket is carried out to create a suitable tapered shape (Fig.12) that could receive the implant. Incremental preparation is used (Fig.7b) before finalizing the site.

Finalization of the placement site is achieved with a dedicated Max drill (Fig.8) specially developed for hard bone. These drills match all the available implant lengths and diameters in the range of the Max implant. In softer bone the pre-placement preparation can be finalized with a dedicated Max tap (Fig.9). Lateral compaction of soft bone is enhanced by the use of this instrument, as is the accuracy of osteotomy site finalization in terms of position and angle.

These taps again, match all the available implant lengths and diameters in the range of the Max implant. They can be hand driven using a surgical wrench as demonstrated in Fig.10 & 11. The taps are specifically designed with a strengthened portion on the driving shaft, near the neck of the instrument. This contains a hexed collar, which slots into a sleeve, allowing connection to a surgical handpiece. Potential instrument fracture and damage to surgical handpieces, are significantly reduced by this innovation.

A third finalization instrument can be used in situations where the interradicular bony anatomy

Fig. 9. Dedicated Max tap

Fig. 10. Dedicated Max tap driven with surgical wrench

Fig. 11. Dedicated Max tap driven with surgical wrench

Fig. 12. Preparation of centrally located interradicular bone septum

Fig. 13. Osteotome in place to assess preparation before implant placement

Fig. 14. Osteotome in place

Fig. 15. Osteotome design

Fig. 16. Osteotome in molar socket used in finalization of preparation

Fig. 17. Max implant for molar extraction sockets

Fig. 18. The 2x2 position rule

Fig. 19. Laser markings on fixture mount at platform level and at 3mm

Fig. 20. Healing abutment connection and soft tissue adaptation with natures

Fig. 21. Healing abutment connection and radiographic evaluation

Fig. 22. Restoration immediately after placement

Fig. 23. Follow up at 1 year
is thin or ill defined. The Max osteotome (Fig.15) also match all the available implant lengths and diameters in the range of the Max implant. It doubles up as a profile gauge which can be used over the osteotomy site to assess the preparation depth and position prior to committing to placement (Fig.13). It is useful to confirm the preparation position radiographically, once preparation finalization has been reached (Fig.14). This instrument has a central stalk with a concave profile. The concave dimples on the base of the instrument are used to steer the osteotome in different directions, while the central dimple on the stalk serves as the main driving point. A rod shaped “chisel” is placed into these concave hollows, which in turn is driven by a surgical mallet. The central stalk is used to retrieve the instrument after use (Fig.16).

The Max range of implants are designed specifically for immediate placement into molar extraction sockets. They are available in 7, 9 and 11mm lengths and in 7, 8 and 9mm diameter. The tapered design makes them ideal for immediate placement in fresh molar extraction sites (Fig.17). They have a moderately rough surface which is created by sandblasting and chemical conditioning with solvents of a grade 4 c.p. titanium. The restorative connection is available in an external hex, tri-nex or internal octagon design. The wide diameter of these implants enables platform switching of at least 0.25mm in the horizontal plane and a further 0.5mm if the 45 degree bevel at the implant shoulder is included.

Accurate and correct placement position and depth is vitally important for the long term success of this treatment protocol. The golden rule is termed the 2x2 position (Fig.18). The implant should always be 2mm below the lowest point of the buccal wall crest and 2mm in (palatally or lingually) from this point. The implant should NEVER touch the buccal bone plate when it reaches its final placement position. Primary stability in the case of a tapered wide diameter implant can be extremely positive and can reach values that are much higher than those we are accustomed to, when using “conventional” diameter dental implants.

The fixture mount on the dental implant has striped laser markings at the implant platform height and at 3mm (Fig.19). These can be used to assist with depth determination during implant placement. Impressions for a temporary or permanent restoration can be completed during implant placement surgery and a wide diameter healing abutment can be placed. Soft tissue adaptation around the healing abutment can be assisted with sutures (Fig.20). A final radiographic assessment ensures a comprehensive assessment of the implant position (Fig.21).

Restoration of the implant can be completed as an immediate protocol or once integration

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Troughing: Detection of three canals in the mesial root of an upper molars

By Dr. Carlos Vidal Tadele

Summary

The complex anatomy of the root canal system is a determining factor in the success of Endodontic therapy. The localization and permeability can become a very complex task even for the most experienced dentists. The combination of the use of the microscope together with the arrival of the ultrasound to the area of the root canal means that manoeuvres such as “trophing” make it easier and more effective to locate the entrance to the conduct. In this article we present some guidelines which will help the dentist to understand and carry out such work together with the illustrations of a clinical case study, in which as a result three main conduct in the buccal root of an upper molar were cleaned, shaped and filled.

Key words

Troughing, Surgical microscope, Ultrasonic, Three canal Mesio-buccal root.

Introduction

The sealing of endodontic pathology is conditioned by the capacity of controlling the infection within the complex system of the root canals (1).

The upper first molar is a tooth that presents a complex anatomy in its mesio-buccal root. Pineda (2), Weine (3), Vertucci (4), and Brown Herbsman (5) describe the anatomical complexities a practitioner should confront.

On the other hand, the identification of three canals in the mesio-buccal root of an upper molar is a fact relatively rare as shown in the specialized literature (5). Traditionally, the DG 16 exploration probe has been the clinical method used to find either the second buccal or lingual root (6).

With the arrival of the Surgical Microscope (7) and the use of ultrasound in endodontic therapy, the “touphing” manoeuvre is being carried out, which means to create a depression or open a path at the floor of the pulp chamber for better access to the orifices of the pulp canals.

The aim of this article is to describe the Troughing manoeuvre and to illustrate a clinical case in which three conductes in the mesio-buccal root of a upper first molar are present.

Classification of orifice for the conductes of the mesio-buccal root

Weine proposes four types to describe the configuration of the main conductes in the mesio-buccal root (3), of the upper molars (Fig. 1):

• Type I: one conduct from the entrance orifice to the apex.
• Type II: two orifices that converge into one at the apical foramen.
• Type III: two orifices of entrance at the pulp chamber and two separated conductes from origin to the apex.
• Type IV: one orifice of entrance at the pulp chamber to throughe into two separate conductes with independent apical foramen.

The configurations of Type II and III represent almost 95% of the cases (Fig. 1).

Classification of vertucci for the mesio-buccal root

• Type I: one conduct, one foramen.
• Type II: two conductes that fuse at the apical third.
• Type III: two conductes that divide in two and re-join into one.
• Type IV: two separate conductes till the apex.
• Type V: one conduct division near the apex.
• Type VI: two conductes that fuse along the root and divide once again at the apex.
• Type VII: one conduct that divides in two and finally has 2 foramina exits.
• Type VIII: three separate canals in exits.

Description of the trophing manoeuvre

A first panoramic view shows the angle line of the orifices of entrance to the mesial root of a upper molar (Figs. 1 and 2).

The technique of access to the pulp chamber is a key procedure for good practice in Endodontic treatment. The opening should be direct at the possible site of entrance of the pulp chamber with refined walls. Over-expansions of the roof of the pulp chamber should be avoided and perfect visualisation should be permitted at all entrances of the conductes, which should be situated at the angle lines between the walls of the pulp chambers and the floor.

The use of the surgical microscope allows a better vision of the dentin we wish to remove in order to locate the conductes.

At first, by using the probe DG16 we locate the three orifices of entry of mesio-buccal, distolabial and palatal conductes, probably in its traditional triangular disposition.

At this point, we should refine the access to the pulp chamber by using ultrasound, in this case directly connected to the equipment house. We use a Kavo scaler (Fig. 5), with a flat head and diamond tip (Komet), which will avoid steps on the pulp chamber floor. Thus, the ultrasound will allow us to eliminate small cal-cifications and delimit the angle lines connecting the three main conductes. Finally the use of the ultrasound permits a direct access for the observation with the Surgical Microscope and the instrumention of the conduct, except of interferences (Fig. 4, 5 and 6).

Among the different options to permeabilization the mesio-buccal conductes 2 and 5, if there were necessary, we propose the Pro-Taper file F1 or Recipro R25 in order to open these extra conductes without permeabilization. No matter how risky this manoeuvre may seem, it is efficient as long as we keep its use to the coronal millimetres and refrain the temptation of continuing to the apical zone of the mesio-buccal conduct, to avoid the screw and blockage effect, which would lead to fracture.

Once opened, the mesio-buccal conductes 2 and 3 are permeabilised with the apical files size 10 and 15, and we can determine our conductometry with the use of apex lockers and continue the instrumentation till the obtura-tion (Figs. 8 and 9).

Discussion

With the NTI rotary files, the new optical illumination, magnifying methods and with the contribution of the ultrasound, the “trophing” manoeuvres are necessary for the opening access of the teeth, both in RCT and retreat, where a high percentage of the refractory chronic cases (10). It is important to full understand the anatomy of the upper first molar and with the help of a microscope ultrasound will be able to master the mesio-buccal root of the upper molars.

In our day to day practice it is normal to find more than two conductes, as it can be observed in the following clinical examples. We need to understand that the mesio-buccal root is oval-shape root and not round root. In most cases if there is more than one canal we will find isth-mus we will need to prepare.
Innovations in Maxillofacial Surgery: Guided Maxillofacial Surgery

By Dr. B. Philippe (MD) Maxillofacial Surgeon

The precise realisation of osteotomies and exact positioning of skeletal parts released by osteotomy maneuvers can be concerns for maxillofacial surgeons. Guided maxillofacial surgery represents one of the latest innovations in maxillofacial surgery and consists of simulating a computer osteotomy to ensure accurate three-dimensional positioning of intraoperative bone cutting and precise drill guides created through the use of miniplates that have been manufactured before surgery with commercially pure porous titanium (CPPTi) under direct metal laser sintering (DMLs).

The size and shape of these prefabricated miniplates will match exactly to the anatomy of the skeletal parts released by osteotomy maneuvers and the spaces created by the respective movement of skeletal fragments. The surgeon can dispose good model miniplates immediately. The joining of these miniplates also eliminates any intraoperative bending that can occur in miniplates and promote precise positioning of the skeletal parts. After creating the computer simulation of the planned osteotomy by the surgeon, the D-COM data of the simulation is sent to the biomedical engineer who then draws the prototype of the osteotomy guide based on the recommendations of the surgeon. The stability of the osteotomy guide on the maxilla is determined by its close contact with the underlying skeleton and this can be augmented by the placement of mini-screws. The design of the osteotomy guide must ascertain the precise execution of the LeFort I osteotomy. Once the design of the osteotomy guide is validated by the surgeon, it is produced using stereolithographic polyamide by stereolithography. (Fig.1)

The design of the custom-made titanium miniplate system completed by the biomedical engineer takes into consideration multiple factors, in particular, the size and form of the system. The miniplate system must lie on the maxilla in a completely passive fashion, without transmitting any tension or trauma to the underlying skeleton. These custom-made miniplates are created as a single unity, initially joined together to allow for their use as a positioning guide. The use of this guide permits maximal congruent contact between the bony segments and the miniplates themselves and thus enables the precise positioning of the skeletal segments freed by the osteotomy. The miniplates are joined together either in 4 x 4 configuration (LeFort 1 osteotomy) or in 2 by 2 configuration (sagittal split, genioplasty). The positioning and depth of the miniplates for osteosynthesis are also simulated. (Fig. 2)

This new system of custom-made titanium miniplates (either 4 x 4 or the 2 x 2) functions intrinsically as a positioning guide and allows for precise positioning and rapid fixation on the maxillary or mandibulay segment. The miniplate system must lie in the best position of placement depending on the specific anatomy of the patient. During virtual surgery planning, the length of the screws and their best position of placement can be ascertained in function to the thickness and density of the underlying bone.

- It decreases the length of time needed for the surgical procedure.
- It decreases any associated trauma to the underlying skeletal structure as it is made in accordance to the individual anatomy of the patient and the desired skeletal displacement of the bony segments.
- It makes the operation much easier for the surgeon and decreases the time spent in the operating room.

Guided maxillofacial surgery is mainly discussed in orthognathic surgery and implant surgery (LeFort 1 indicated for maxillary acquired atrophy) but other applications can also benefit from guided surgery:

- In patients who have unilaterial deformities, the final result of the facial bone reduction and fixation can be based on the contralateral normal skeleton.

In this situation, the miniplate system can be designed based upon a contralateral face by symmetrising digitally from the midline.

- All cranio-maxillofacial osteotomies or maxillofacial reconstructions may benefit from this new type of custom-fit miniplate osteosynthesis.

References

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Orthodontic Seminars – by Dr Fabien Depardieu
- Restorative/Orthodontic interface: Working together to get the best results for our patients
- Orthodontics in 2015: What’s new
- Facial Aesthetics
- Orthognathic surgery

Oral surgery seminars – by Dr David Roze
- Immediate implant into a fresh socket
- Oral surgery in the dental clinic: Review and results
- Implant crown restoration

Fig 1: LeFort I and Genioplasty cutting guides
Fig 2: LeFort I and Genioplasty custom made miniplates. Conflict of Interest: No
Always a perfect healing with P.R.F. (platelet-rich fibrin)

By Dr. Dominique Caron

After any weird wisdom tooth extraction here is a first quick introduction to a smart technique.

You are happy, your busy complicated §8, looking like a plug for hollow brick, is out.

You performed the removal nicely but you are now preparing the second step, which is not nicely but you are now preparing the second step, which is not.

There is a very efficient way of helping nature, to give the times and the means to recover: You can bring massively in the socket the natural angiogenic, circatricial rebuilding material that the body naturally brings too slowly.

You need fibrin, platelets, leukocytes, cytokines and growth factors.

All of these components are available in patient’s blood, all you have to do is to extract it and concentrate it in the socket.

The process

Just before starting the surgery, you arrange the clot filling the socket (that allows much less food collection):

- Hemostasis: You get a quick clot!
- Accelerated tissue remodeling:
  - Fast neovascularization.
  - Bone resorption is much less significant.
  - Pain is reduced
  - Even lower risk of infection
  - Inflammation is lower during the following days
  - Accelerated tissue remodeling:
  - EFFICIENT: Enhances the body's natural healing.

What does it change?

- The dental nerve is immediately protected.
- The clotting cascade starts immediately so try to be quick with the clotting.
- The clot filling the socket (that allows much less food collection)
- Hemostasis: You get a quick clot!
- Accelerated tissue remodeling:
  - Fast neovascularization.
  - Bone resorption is much less significant.
  - Pain is reduced
  - Even lower risk of infection
  - Inflammation is lower during the following days
  - Accelerated tissue remodeling:
  - EFFICIENT: Enhances the body's natural healing.

To conclude, this smart French technique can render your patient’s life and yours much happier!

Stay tuned for further articles with all other applications.

References
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“The Middle Eastern dental market is one of the fastest growing markets worldwide”

By Dental Tribune MEA

DUBAI, UAE: Ritter Concept is known for offering 127 years of Dental Experience. The German owned and operated company has all their products ‘Made in Germany’ at the modern production facility located in Zwickau (Saxony, East Germany). The company is known for a Leading Edge Design and High Level of Function. We interview the CEO of Ritter, Mr. Werner Schmitz to find out his thoughts on Dentistry.

Dental Tribune MEA: Mr. Werner Schmitz, it is a pleasure to interview you. Could you tell us how you became involved with Ritter and the changes that have taken place since you became CEO?

Mr. Werner Schmitz: When I took over Ritter in 2004, the company faced a relatively difficult situation. In the following years the business has been continuously built up. We re-launched our portfolio and amended it with modern and highly innovative dental units, autoclaves, compressors and x-ray devices in order to offer an overall concept to the dentists. Step by step we re-gained the confidence and trust of our customers. Today the Ritter product range contains more than 20 product divisions, which are available worldwide. Users appreciate Ritter products for their high product quality, innovative technologies, reliability and easy maintenance aspects – Made in Germany.

How does Ritter stand out amongst the highly competitive dental industry?

Ritter is able to benefit from a 127-year-old history and the corresponding experience. Though we foster the old values of a still owner-managed company, combined with modern processes and products, in our daily work as well as in the relationship to our customers. Therefore the - let’s say Unique Selling Point - “owner-managed” is relevant for the company’s success. Most of the German companies are characterized by rational and economic intentions, which are dictated by the investors. Ritter’s understanding of a company’s philosophy is completely different and based on a mutual understanding and a fair and reasonable partnership. Ultimately I haven’t made all these efforts within the last 11 years in order to sell the company at a later point. I will rather pass it over to my family and children. The stability of values is not only reflected in our image, but also in our product range. Ritter does not use standard plastic components for the products, but parts made from fiberglass, metal, aluminum, etc. The difference is obvious: Longevity, solidity and low needs for service or repairs. Paired with our flexibility and lean structures, Ritter is able to offer premium products at a very interesting price-to-performance ratio to the users.

As of 1st of June 2014 Ritter signed a deal with Henry Schein for an exclusive cooperation for the Middle East. How has and will this help you to develop your presence here in the MEA region?

Ritter is delighted to set up the latest sales and service approach with such a strong and internationally experienced partner like Henry Schein. We believe, that the mix of local background and knowledge of two global companies will be the gateway to success. Henry Schein Middle East LLC is based in Dubai directly. All customer requests can be handled locally, in a quick and flexible way. The technical engineers are specialised in the installation and service of dental equipment. Moreover Henry Schein provides a strong network of dedicated Henry Schein distributors in each country. The experienced Ritter Export Managers support all activities continuously. The customers receive a full-service spectrum of care. Also the upcoming tradeshows in Dubai represents a good opportunity to show our common strengths. We strongly believe that this partnership will create a wide range of synergies and services from which our clients will benefit.

What is your impression of the Middle Eastern Dental Market and level of Dentistry?

In my opinion the Middle Eastern Dental Market is one of the fastest growing markets worldwide. Users emphasise on high-level products with outstanding quality aspects. Also the product design plays an important role. Practices in the Middle East are equipped in a very modern and innovative way and the users attach importance to provide first class dental treatments to their patients. To all these aspects, Ritter has the appropriate answer with a sophisticated range of products and services.

How do you educate your current clients and what are your plans in enlarging your client portfolios in the region?

Mr. Werner Schmitz, CEO took over Ritter in 2004

> Page 28
For 2015 we worked out a joined marketing plan with our exclusive partner Henry Schein. This contains a wide range of activities, press releases and reports in dental newspapers, magazines and online media. On the ground we will provide information by the means of local showrooms and VIP clinics. These institutions will offer access for interested dentists to Ritter dental units and products. Also the user in the VIP clinics will share their experiences in daily work with Ritter products. Also trainings for dentists and technicians will be available in several local areas. For us it is crucial to provide direct personal consultancy and comprehensive local services to our customers.

In this IDS year, will there be more new developments for Ritter which we will see in the Middle East & Africa region?

Of course we will present novelities in the fields of dental units, x-ray devices and compression suction. We are more than proud to show our new and modern dental unit ARIA SR with outstanding design-opportunities and convincing qualitative aspects for every user. The ARIA SR will bring a new understanding of modern dental units into the practices worldwide. More detailed information about the new products will be presented during the tradeshow in Dubai in February and later this year during the IDS in Cologne in March. This means, the Middle Eastern countries will benefit from being one step ahead regarding the product launch.

What do you expect form Dental Tribune Middle East & Africa?

For sure the Dental Tribune MEA offers a great platform of communication to us. Our expectation is to spread the message of the Ritter products, technologies, support and training services within the users in the Middle Eastern countries and to cover all informative aspects. In this regard we trust in the support of Dental Tribune MEA, which is always present on the pulse of events and happenings.

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26th SDS Int’l Dental Conference was attended by over 3000 participants
13-15 January 2015, Riyadh International Convention and Exhibition Center, Riyadh

By Saudi Dental Society

The Saudi Dental Society recently held its most important and the largest scientific gathering in the Kingdom. The 26th Saudi Dental Society International Dental Conference with this year’s theme, “Innovative Digital Solutions in Dentistry” was held last 13-15 January 2015 (22-24 Rabi’1 1436H) at the Riyadh International Convention and Exhibition Center in Riyadh, Saudi Arabia. The conference was attended by over 3000 participants (dental specialist, dental technicians and assistants) from the various government and private sectors, universities, hospital and institutions.

The celebration commenced with an opening ceremony attended by highly distinguished guests led by the Prince of Riyadh and other dignitaries and guests.

The six scientific sessions featured lecture presentations given by 18 international keynote speakers from USA, UK, Germany, Switzerland, Sweden, Brazil, France, Spain, Netherlands, Lebanon, Jordan and Canada including 8 local speakers on various dental specialties. In addition to the 11 Continuing Education Courses and Workshops conducted during the three-day conference, two pre-conference workshops were given on 10-12 January 2015.

The highlight of the conference was the Research Award’s Competition for the Young and Graduated Dentists and Poster Presentation Competitions. There were four presenters for the Young Dentists, six presenters for the Graduate Dentists and 127 posters offered the opportunity for other participants to present their research in poster sessions.

The scientific program was also complemented by 55 well-organized exhibitions of numerous leading medical and dental companies featuring the latest equipment, materials and devices in the medical and dental world.
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Pre-Registration is Mandatory as it is a limited Participation Program.
For further information and registration details visit website: www.aaid-asia.org or e-mail Dr. Ninette Banday, Dental Services Manager, Restorative Dentist & Implantologist, AHS-SEHA, Abu Dhabi
Coordinator AAID-MaxiCourse UAE at drnbandy@yahoo.com.
Henry Schein Middle East welcomes VIP’s in world’s tallest hotel – Marriott Marquise Hotel Dubai

By Dental Tribune MEA

DUBAI, UAE: Tuesday 17th February 2015, Henry Schein Middle East gathered over 120 VIP customers and dealers from the Middle East region for a remarkable event in the world’s tallest hotel, Marriott Marquise Dubai.

Henry Schein is the largest global dental distributor of health care products and services to general practitioners, specialists and laboratories throughout the world. The primary objective of the company is to partner with its customers in order to improve the practice efficiency and productivity that enables the customers to focus on delivering quality care to their patients. The network of exclusive Henry Schein Middle East Distributors offer dentists a complete portfolio from high quality and value priced consumable and equipment product manufacturers that customers can rely on to fulfill their practice needs.

In the middle of the Emirates Ballroom at the skyscraping Marriott Marquise stood a complete built clinic including 12 different manufacturers that can supply all the requirements for the daily use of a dental clinic with different dental specialties. The Henry Schein Exclusive Partners including Henry Schein Brand Products, ACE Surgical Supply, B.A. International, BUSA Dental Instruments, Camlog, Ortho Organizers and Henry Schein Connect Dental. The Henry Schein Exclusive Suppliers Partners included Air Techniques, CAO Group, Osstell, Planmeca and Ritter Dental.

Dr. Ghassan Nasser (Sales & Marketing Director Middle East and North Africa) together with Mr. George Aalto (General Manager, International Dealer Sales) opened the evening with two presentations on the overview of Henry Schein as a leading dental supplier company worldwide and the future plans for the Middle East and North Africa markets. Managers from the 12 dental manufacturers of Henry Schein companies had the chance to meet the VIP customers and dealers from the Middle East and discuss opportunities, business plans and product features.

Amongst the guests were Prof. Donald Ferguson (Dean European University College - Second from r.t.l) and Dr. Joseph Samy (Assistant Dean European University College - Far right)

Dr. Ghassan Nasser (Second from L.r.) - Sales & Marketing Director MEA and Mr. George Aalto (Third from L.r.) - Henry Schein together with guests

Dental Tribune International together with Dental Tribune MEA & CAPP

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Mr. George Aalto speaks on the exclusive partners and Suppliers

A complete built clinic including 12 different manufacturers that can supply all the requirements for the daily use of a dental clinic

Guests witnessing firsthand the latest products

The Gala Dinner was well attended at the Marriot Marquise Hotel in Dubai (Worlds tallest Hotel)
Unilever unveils scientific data supporting REGENERATE Enamel Science™, the new dental care system proven to reverse the Enamel erosion process

Unique NR-5™ Technology Provides Clinically Proven Superior Enamel Re-Hardening Compared With Fluoride-Only Toothpaste1

By Unilever

Dubai, UAE: 16 February 2015 – New data presented at IADR Cape Town on 26th June, now published in the Journal of Dentistry, demonstrate the efficacy of Unilever’s REGENERATE Enamel Science™, the newly launched dental care system proven to help reverse the early and invisible stages of the enamel erosion process.

REGENERATE Enamel Science™ is the first and only system proven to form hydroxyapatite, with identical composition to underlying enamel mineral. The dental care system, with its unique internationally patented NR-5™ technology, helps recover 82% of enamel hardness after three days of use1. A new in situ study shows that the novel technology in REGENERATE Enamel Science™ is effective in the mouth and is able to re-harden enamel significantly better than fluoride-only toothpaste2

Inspired by research on bone repair technology, Unilever Oral Care scientists carried out both in vitro and in situ studies, which proved that calcium silicate can deposit onto sound and eroded enamel. Upon this discovery, the novel NR-5™ technology was developed to augment the natural mineralization processes of human saliva by providing a combination of calcium silicate and sodium phosphate, which help to form a fresh supply of hydroxyapatite that wraps and integrates onto teeth1.

Professor Nicola West, Honorary Consultant in Restorative Dentistry (University of Bristol UK), who was involved in the in vitro research on REGENERATE Enamel Science™ system, says: “Erosive tooth wear by dietary acids is a real dental health issue and a growing problem. Patients are concerned about their tooth wear, which often results in sensitive teeth. Dentists and patients find erosive tooth wear hard to manage and treatment solutions for it are limited. We now have new proven scientific evidence, published in high impact dental journals, showing that NR-5™ technology works to remineralise the tooth, and this solution to tooth wear is fast acting and easy to use.”

Speaking about the technology that has been developed through over 9 years of research, Unilever’s oral care researcher who led the team, Fred Schäfer says: “The innovative mechanism of action of the calcium silicate and sodium phosphate in this novel dental care system provides enamel re-hardening that is significantly greater than with fluoride-only toothpaste. This new approach has been proven to help restore acid-challenged enamel.”

The REGENERATE Enamel Science™ system consists of an Advanced Toothpaste for daily brushing and a Boosting Serum (with two custom-fit mouth trays) for application at home, monthly for 3 consecutive days. When used in combination with the daily Advanced Toothpaste, the Boosting Serum increases the Advanced Toothpaste effectiveness to 45%**, enhancing the power of enamel regeneration.

The scientific studies have been published in the June 2014 supplement of the Journal of Dentistry. A link to these studies can be found on the REGENERATE Enamel Science™ website: www.RegenerateNR5.com.

Regenerate Enamel Science™ can be found exclusively at Boots Pharmacy across the UAE starting from the below prices: - REGENERATE Enamel Science™ Advanced Toothpaste, AED 100 - REGENERATE Enamel Science™ Boosting Serum, AED 60

References

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Henry Schein is a name you can trust.
Carestream Dental CS Adapt – Allows users to choose how they want to see their Images

By Ernesto Jaconelli

CS Adapt is a new processing and software module available for Carestream Dental extraoral systems. The module allows practitioners to optimize image contrast for all 2D panoramic and cephalometric exams according to their diagnostic needs and visual preference for faster, more accurate diagnoses in any indication.

“What makes CS Adapt unique is its ability to adapt to the user, not the other way around,” said Stéphane Varlet, Product Line Manager, Extraoral Imaging, Carestream Dental. “The software automatically produces optimized images and personalizes their look and feel to the individual needs of the practitioner.”

Users can either define their own preferred image looks or choose from pre-set enhancement filters, resulting in a customized comfort zone for every diagnosis. Up to six pre-set filters—Original, Sharp, Contrast, Dynamic, Smooth and T-Mat film—are available to optimize images. Plus, no manual adjustment is required—preferred looks can be applied by default or assigned to software icons, so practitioners can access them with a single click. CS Adapt capabilities are also available for cephalometric images, along with Carestream Dental’s three popular orthodontic filters that improve image clarity and outline soft tissue.

CS Adapt represents next-generation image processing technology. Using multi-frequency image processing, powerful algorithms deliver impressive image quality and clarity. Images are divided into multiple layers—anatomy, hard and soft tissues, contrast, sharpness, noise—and processed separately to obtain the highest image quality of each layer. The layers are then recombined to reconstruct the final image. An artifact-free filter prevents the creation of dark halos, making clinically relevant details more visible for better and more confident diagnoses.

This intuitive module allows practitioners to easily browse, select and save preferred looks and settings using the CS Adapt Library. The CS Adapt Library features side-by-side image display and real-time changes to facilitate selection and adjustment of the pre-defined looks. Favorite settings can even be saved and applied individually on each workstation or on all workstations at once.

“Regardless of the Carestream Dental equipment practitioners are using, they can achieve consistent, high-quality images across our extraoral solutions,” said Edward Shellard, D.M.D., chief commercial officer for Carestream Dental. “CS Adapt integrates with any new Carestream Dental extraoral system and is available as a simple software upgrade for all previously installed extraoral equipment*.

CS Adapt will also be available as a module for the RVG 6200 sensor.

*excludes the 8000/8000C and 9500

For more information about the CS Adapt module, or any of Carestream Dental’s extraoral solutions, please call our Carestream Dental Dubai Office on +9714 40 77 803 or visit www.carestreamdental.com

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Inman Aligner and Intelligent Alignment Systems are pleased to announce our annual symposium. Following a superb 2014 meeting in Copenhagen our 2015 venue is DUBAI! We have a world renowned line-up of speakers.

We have secured fantastic room rates at the exclusive Jumeirah Beach Hotel during peak season Only 900 AED (£160 / €216 / $245) + tax

We are also pleased to share the venue in a joint meeting with the 7th Dental - Facial Cosmetic International Conference (DFCIC) so those wanting to combine some winter sun with even more superb CPD can combine both meetings.

IAS Symposium
Who for All Inman and CAPP delegates
Summary This day is designed to deliver a condensed wealth of information and motivation to grow your cosmetic practice. CAPP and Intelligent Alignment Systems have worked together to bring a highly respected team of dentists from all over Europe.

Dr Tif Qureshi
(Past President British Academy Cosmetic Dentistry) Current trends in Anterior Aesthetic Orthodontics! Interceptive Occlusal Dentistry - the new path for dentistry

Dr James Russell
(Accredited by British Academy Cosmetic Dentistry) GDP Orthodontic pre-alignment prior to composite bonding and veneers - a technique case study

Dr Jason Smithson
(Global authority on composite artistry) Emulating natures morphology with direct composite

Dr Jens Nolle
(Private Dentist and lead IAS trainer in Germany) Creating the dream aesthetic practice

Dr Andy Wallace
(Vice President of European Society of Aesthetic Orthodontics) Why EVERY Dentist should offer simple orthodontics!

Dr Richard Field
(Young Private Dentist of the Year 2014) Essential Dental Photography - made exquisite

Dr Charlotte Nyby
(President of New Holistic Dentistry - Denmark) Using the Alignment - Bleaching - Bonding Protocol to make dentistry more profitable and more fun with less stress

Inman Aligner Update Course
Who for Certified Inman Aligner Dentists
Summary The 2015 installment of the highly rated update course. A day packed or the latest tips and techniques to boost your Inman Aligner treatments.

7th Dental - Facial Cosmetic International
Who for All Dentists
Summary This very popular conference regularly has over 1000 delegates. A wide range of lectures, all in one room means delegates can enjoy multiple topics without needing to decide what to listen to. Many of the Inman Trainers have spoken at and attended this conference. More information about speakers at: www.cappmea.com/aesthetic2015/speakers.html

Inman Aligner Certification Course
Who for All Dentists
Summary This is the required course to become a provider of the Inman Aligner orthodontic appliance. This hugely popular and highly rated course has been running for over 7 years all over the world.

Inman Aligner Advanced Course
Who for Certified Inman Aligner Dentists
Summary This course, run by Tif Qureshi, is designed to allow experienced Inman Aligner users to treat more complex cases with confidence. We recommend that dentists have completed at least 10 cases to make sure they benefit from this training. More information at www.inmanalignertraining.com
FKG Dentaire: a new era in Endodontics

By FKG

Following the success of last year, FKG Dentaire has created a dedicated space on its booth for free Workshops. The demand was extremely high and most of the available spaces were booked for all AEEC on day one. Should anyone be interested to attend such workshops on FKG Dentaire instruments and materials, free trainings are available in FKG Dentaire Dubai Training center (information and booking: mea@fkkg.ch).

Dr Guillaume Jouanny (University of Pennsylvania, USA) and Pr Roger Bebeiz (Dental College, Lebanon) Lectures and Workshops on Rotary and latest generations of Bio Ceramics Sealers and Root Repair Materials (Race and TotalFill) were outstanding. This success proves once again that the tendency in Endodontics is toward a more conservative and biologic approach. Race files (over 120 different sizes, length and tapers available) in addition of being non screwing compare to other systems on the market allows dentists to increase the size of the their treatments apically respecting the root anatomy avoiding over enlargements.

The Root Canal Anatomy not being round, the files available today on the market leave untreated areas ranged from 59.6% to 79.9% (F. Paqué, et al JOE 2010;36 (4):703-707).

Following this observation, over the last years FKG Team and some worldwide known dentists and endodontists have been working hard on finding a way to increase treatment quality and success rate by creating a new generation of files. Thought out of the box, they will increase dramatically the areas treated, respecting the roots anatomy by adapting their shape to it while preserving dentine!

The Xpendo file will be launch at IDS 2015 in Germany, on FKG Dentaire booth (Hall 4.2, Stand G28/J29).

Pr. Roger Bebeiz providing hands-on courses at the FKG booth at the trade show.

The Swiss Pavilion was again largely visited.

A sneak peak of FKG workshops on Endodontics. FKG recently opened their showroom in JLT in Dubai, UAE.

3D efficiency
optimal cleaning while preserving dentine

FKG Dentaire SA
www.fkg.ch
AAA - After Appointment Action

By Dr. Ehab Heikal

A very typical frustration for many dentists is to have cancelled appointments. And I have discussed in another section of my book, that such cases should be punished in case of no show.

However; the coercive action of punishment is a tool to minimize such incidents, so it is not the aim. Especially that, in some cases, you cannot punish the patient if the appointment is cancelled early enough.

And my concern now is not regarding your clients or existing patients, I am concerned now with your new patients that have never been treated at your office before.

So what happens between the time of appointment setting and the time of cancellation?

The simplest thing is that the patients could get busy, and since they will not consider the dental treatment as a priority compared to whatever came up and they have to do. They will find no motive preventing them from re-scheduling or cancelling the appointment. *I have too many things to do today—I’ll just cancel my appointment.*

What also helps is that a dental appointment is not a pleasant one for many reasons you know. Also they might be attracted to another dentist through word of mouth. For example, Sally was discussing with her friends the treatment plan she is planning to perform at your clinic, or the filling she is about to have, and of course the fear of pain will be a major player in the discussion, so Suzan suggests that Sally goes to her (Suzan’s) dentist as she has never felt any pain at his clinic. Here we have a shift through an opinion leader for Sally based on the motive of avoidance of pain.

Or consider this patient thinking: *I should be going back to my old dentist—he wasn’t great, but I knew him. Why am I changing?*

Here the fear of change is the motive. Or the theory of: the bad I know is better than the good I don’t know!!!

I can list hundreds of examples, but that is not my point. My aim is to assist you in overcoming those complications.

We have to set a motive and help the patient by throwing the rope and pulling him/her to our clinic.

You need to make it easier for your patient to mentally confirm the appointment, and to eliminate the hesitation barrier.

The Professional New Patient Kit

There is one simple way; you need to create a Professional New Patient Kit. This could be an electronic kit for internet and computer users, or a hard copy kit that you can send via any local courier in town.

You need to send this kit out the same day you set the appointment.

The kit is composed of a brochure—an appointment card—even a welcome letter—plus a complimentary copy of your newsletter. Effectively, each piece responds to a different unasked question, building confidence and commitment on the spot!

How the components work together

The Welcome Letter is a conversational greeting between you and your new patient—the equivalent of eye contact and a handshake.

The Welcome Brochure introduces you and your practice. It outlines your clinical credibility, maps your location, lists your services. And, most important, answers the unasked questions: Will you understand my fears? Can you protect me from communicable diseases? How will you handle my emergency?

The Appointment Card confirms date and time—subconsciously strengthening resolve to keep the appointment.

Your Clinic Newsletter demonstrates your commitment to informative communication with every patient.

Research shows that going to the dentist is very low on the list of things people like to do. One of the key reservations is fear of the unknown. The worst part of this factor is that most people are too embarrassed to ask questions. Your brochure should answer the questions so there’s no need for people to be fearful.

The Welcome Brochure answers them for you automatically—before the very first appointment! The way is paved, and that tenuous connection between you and the first-timer grows to a positive commitment.

Dr. Ehab Heikal
BDS.MBA.DBA
Practice Management consultant
eheikal@eheikal.com
Interview: “This is the only pain management tool that instills a sense of mastery”

By Anne Faulmann, DT

Visits to the doctor can be a distressing experience, especially for children. Procedures that are likely to involve pain, such as vaccinations, blood tests and dental interventions, are stressful for young patients, their parents, physicians and nurses. In order to help children cope with pain and to make visits to the dentist and doctor a more pleasant experience generally, a team of researchers at the University of Calgary have developed MEDi, an innovative robotic pain management tool. Dental Tribune Online spoke with Dr. Tanya Beran, Professor at the Cumming School of Medicine at the university and Founder and Chief Scientific Officer of RaRobots, where MEDi was invented.

Dental Tribune Online: Dr. Beran, how did you come up with the idea for a medical robot to help children cope with pain?

Dr. Tanya Beran: At a child development conference, I saw a video of a teenage boy interacting with a robot. Not only did he show empathy, but he also tried to help the robot. I could not understand why and there was almost nothing in the research. So I started my own, I was surprised to find that children and teenagers tend to think that robots are alive. Now, while working at a children’s hospital, I found it alarming to watch children screaming, struggling, and pleading not to have a needle. I realized that medical procedures need to be easier, faster and far less painful. Then I put two and two together. I thought maybe children would respond to a friendly robot to help them deal with pain.

Could you please explain how MEDi works and what kind of tasks he performs?

We program MEDi with cognitive-behavioral interventions that research shows do work. Some of these include instructions to take deep breaths to relax the muscles, framing (replacing a negative thought with a positive one), and positive reinforcement (the robot providing a reward). When we teach coping strategies to children, they tend to forget to use them. When we teach them to parents, they tend to use them ineffectively and may even exacerbate children’s anxiety. For example, telling a child that it will be ok, how can they forget to use them it is not really true. However, the robot is able to effectively deliver the interventions every time.

Why is MEDi a useful tool during medical procedures, especially for children?

The robot is endearing to children and has like-like movements. It provides both distraction and pain coaching. MEDi encourages children so they can develop a sense of mastery to deal with the procedure that they can then transfer to other procedures. For example, one mother shared with us that, as a result of her daughter having a blood test with MEDi, for the very first time afterwards, she started talking with her oncologist. The mother believed that this confidence to speak up for herself was due to the positive support her daughter received from MEDi. This is the only pain management tool that instills a sense of mastery.

How can MEDi be of use during dental procedures?

As with any medical procedure, such as vaccinations and blood tests, MEDi can provide the same support during dental procedures that involve a needle. In addition, children have anxiety and fear about medical procedures that are not painful, like having a radiograph taken or an EEG test. MEDi can also work for dental procedures that are not painful to calm nerves, provide comfort, and distract children from negative thoughts and feelings. Our research showed that MEDi increased cooperation from children so the procedures could be completed more quickly and with greater satisfaction from children and their parents.

Has MEDi already been applied successfully in dental practices or have there been any tests regarding MEDi’s effectiveness during dental procedures?

We are looking for a partner in dental practice who would like to bring MEDi in to work with their patients. From our randomized controlled trials, we have evidence that MEDi reduces pain and distress, and we expect to find similar results for other procedures, including dental ones. MEDi attracts patients to clinics. One family drove 60 km for their son to be vaccinated with MEDi, so there could be a competitive advantage for dental clinics as well. Several parents have asked us to create applications for MEDi in dentistry.

MEDi has been developed and tested in Canada. Do you think that it would work in other countries with a different cultural background as well?

MEDi can be programmed with a variety of behaviors and can speak in 20 languages. The words and actions can be selected to be culturally appropriate and highly engaging for children of all ages and developmental abilities. The robot is only limited by our imagination on how to program it.

Contact details available from the publisher.

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• Natural anorganic bovine bone matrix; available in 6 different forms to best suit your surgical needs

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Contact Your Local ACE Surgical Dealer.
By Eniko Simon

D uring any work advising dental practices, many practice owners complain about not having enough patients, or that patients do not return for treatment. It is a common problem in any dental business.

In this article I wish to share some tips to help you to reduce these problems and explain how could a patient centered clinic management approach and enhanced patient journey aid the treatment acceptance in your clinic:

• Your clinic: the patient decided to come

Treatment Acceptance

Whenever we decide to buy a product or a service we do it for one simple reason; we decide to buy it as it offers a solution for our problems. We buy a laptop as we need to make sure we can help the patient to understand the problem when you understand the treatment. Provide them with testimonials from other patients that have gone through the same procedure.

• Make the treatment possible – Here we are talking about the financial side. This is the most challenging part; you should not provide your services too cheaply as this you as a dentist under value yourself, however you need to make sure your patient can help the patient afford the treatment.

We can do this by offering different payment options to the patient.

• Implement the role of the treatment coordinator in your practice – It can be one of the nurses or one of the receptionist who is trained as a treatment coordinator or has some experience. The treatment coordinator plays a vital role in increasing treatment acceptance.

The Role of the Treatment Coordinator

The treatment coordinator role has grown steadily in the US and UK in the past 10 years. The treatment coordinator is not only there to assist the dentist in preparing and presenting the treatment plan but also increasing the treatment conversion by providing an enhanced patient journey / patient experience in the dental clinic.

New patient consultation

The first consultation with the treatment coordinator is an informal chat between the patient and your treatment coordinator (TCD) when the TCD asks questions to find out the dental concerns of the patient and introduces the clinician to the patient. It is really the first step to build rapport and make the patient feel comfortable in your clinic. This consultation should be a free consultation to your new patient that you can schedule before the clinical consultation.

Build rapport

The treatment coordinator assists the dentist in preparing the treatment plan and in presenting the treatment plan to the patient. They should always spend some more time with the patient after the treatment plan has been presented to answer any further questions the patient may have and discuss payment options.

This discussion can also help to overcome any objections or doubts the patient may still have. The treatment coordinator should be a trusted contact who is there to support the patient along the way through the journey within the clinic.

Keeping in touch

The treatment coordinator should make the person who follows up with the patients – after treatment planning, making the treatment plan, etc. – The treatment coordinator plays a vital role in increasing treatment acceptance and increased profit. If you wish to implement the role of a treatment coordinator or would like to get to know more about how a TCO could help your clinic, please contact me – I am happy to answer any questions.

Contact Information

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Dental Business Manager
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In the centre of attention – How to run a patient centered dental clinic

By Fiona Stuart-Wilson

E ach year some practices have to deal with an emergency – not a medical emergency but a business emergency. Although most of us will have most of our buy insurance, we do so on the basis that we hope that the risks we are insuring our practices against will never actually happen. Of course the likelihood of the sort of risk occurring which would affect our ability to operate as a dental practice is low but there is no getting away from the fact that the unexpected does happen, and insurance is really important as the patient feels we do care about them – a little extra effort that makes a difference.

I believe the treatment coordinator greatly helps to reduce the dentists’ non clinical time with the patient, helps to provide an outstanding patient care in your clinic. If we implement these tips, there is increased treatment acceptance and increased profit. If you wish to implement the role of the treatment coordinator or would like to get to know more about how a TCO could help your clinic, please contact me – I am happy to answer any questions.

Preparing for the worst

By Fiona Stuart-Wilson

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By Dental Tribune International

BIRMINGHAM, Ala., USA: Today, general dentists in the U.S. and other parts of the world provide a comprehensive range of services. However, there has been only limited research on which specific procedures are performed most commonly by this group. Now, a new study has shown that non-implant restorative treatments, esthetic procedures, and extractions are routinely performed by the majority of general dentists. Over 60 percent also provide implant treatments.

In order to determine the ten most commonly performed dental procedures, data from 2,367 general dentists in the U.S. National Dental Practice-Based Research Network were collected via a questionnaire.

The majority of participants stated that they perform non-implant restorative treatments (96 percent), esthetic procedures (90 percent), and extractions (64 percent) on a regular basis. Almost 60 percent said that they also perform endodontic therapy. While orthodontic treatments and periodontal surgery were not common among two-thirds of the participants, over 60 percent stated that they perform dental implant procedures occasionally or routinely.

The study also found that more male dentists performed endodontic procedures, implant treatments and surgical periodontal therapy than did their female counterparts.

As a considerable number of general dentists interviewed reported performing at least some endodontic procedures and periodontal surgery, it is possible that provision of such services is a means for general dentists to adapt to the availability of dental specialists and to overall demand for services in their practices, the researchers said.

“These findings may have implications for how general dentists respond to the changing picture of dental economics...”

The study, titled “Provision of Specific Dental Procedures by General Dentists in the National Dental Practice-Based Research Network: Questionnaire Findings,” was published online on Jan. 22 in the BMC Oral Health journal. It was conducted by researchers at the University of Alabama at Birmingham in collaboration with other scientific research institutions throughout the U.S.
KaVo donates dental treatment unit to UNESCO village in Sri Lanka

By Dental Tribune International

A HUNGALLA & KOSGODA, Sri Lanka: Recently, KaVo Dental, an international manufacturer of dental instruments, equipment and imaging technology, donated one of its dental treatment units to a development aid project in Sri Lanka. Through the donation, people living in the UNESCO village south-west of Sri Lanka will have access to dental treatment in the future.

“KaVo has now donated a dental treatment unit to the village, where 34 families live.”

On 26 December 2004, large parts of Indonesia were struck by an Indian Ocean earthquake that resulted in a tsunami. The plight of the affected countries, including Sri Lanka, India, Thailand and Somalia, prompted a worldwide humanitarian response. Ahungalla and Kosgoda, two communities in the south-west of Sri Lanka, were very hard hit: 200 people lost their lives and about 400 houses were destroyed. Shortly after the catastrophe, German charity organisation Future for Children helped build a UNESCO village within a few months.

KaVo has now donated a dental treatment unit to the village, where 54 families live. The second-hand ESTETICA Comfort 1005 unit was completely refurbished by the company’s service team. In December 2014, monk Winnaladhamma Tissa Nayaka from the UNESCO village and Elfride Süß (Future for Children) at KaVo’s production site in Germany.

BEGO celebrates 125th anniversary

By Dental Tribune International

BREMEN/Cologne, Germany: BEGO, a German-based provider of dental equipment and materials, has announced the launch of the “Building the Future for 125 Years—Happy Birthday BEGO” campaign in celebration of its 125th anniversary. To kick off a year of celebrations, the company will unveil its new 3-D printer, Varseo, at the upcoming International Dental Show (IDS) in Cologne.

“2015 is set to be a very special year...”

In Cologne, the company will be introducing its latest self-developed 3-D printing system to the public. Varseo is optimised for dental applications and allows for the production of a wide range of plastic items in the laboratory. In addition to the printer, associated materials, software tools and services, such as splints, surgical guides, CAD/CAM partial denture frames and customised impression trays, will be on display.

BEGO was founded in 1890 by Dr William Herbst in Bremen. Today, the family-run company has an international workforce of approximately 450 in its Bego Dental, BEGO Medical and BEGO Implant Systems divisions.
This morning your patient just washed away an important sign of gum disease

Include parodontax® toothpaste as part of your recommendations to help stop bleeding gums

parodontax®

References:
parodontax is a registered trade mark of the GlaxoSmithKline group of companies.
“Smile for life” campaign: FDI encourages people to limit sugar intake

By Dental Tribune International

GENEVA, Switzerland: As World Oral Health Day (WOHD) 2015 approaches, FDI World Dental Federation advises people to consider the impact of frequent sugar consumption on their smile for life. Dental caries is the most common non-communicable disease in the world, and research has demonstrated that sugars are the main cause of tooth decay.

When one eats or drinks something sugary, the bacteria in the plaque feeds on the sugar and releases acid that attacks teeth for about one hour. Frequent consumption of sugar results in prolonged acid attacks, weakening the protective outer layer of the teeth.

Speaking about this process, Dr Jaime Edelson, chairperson of the FDI WOHD task team, commented: “Sugar reacts with bacteria in the mouth, which together form an acid that damages the enamel. When this keeps happening, a hole is formed in the tooth, which then requires filling and may over time lead to an extraction. By paying close attention to how often we are consuming sugary foods and drinks, the number of acid attacks on our teeth can be reduced.”

WOHD is an opportunity for the FDI to draw attention to proven oral care behaviours that people can adopt to protect their teeth—for life. These include brushing twice a day with a fluoride toothpaste, cutting down on consumption of sugary foods and drinks between meals, and chewing sugar-free gum after meals and snacks when on the go and brushing is not feasible.

FDI President Dr Tin Chun Wong commented, the theme of “World Oral Health Day 2015, ‘Smile for life’, has a double meaning—lifelong smile and celebrating life. Smiling implies self-confidence and having fun, as people only smile if they are happy and have a healthy life. Please take the time to consider your oral health and bring a smile to everyone around you.”

world’s largest manufacturers of dental technology, with a product portfolio that has placed it in the vanguard of the industry. “We received a unique opportunity to share our growth story with the Swedish leaders and to introduce to them our newest dental and healthcare innovations, such as combinations of patient 3-D data. Thanks to the emergence of 3-D technologies and applications, dental care is undergoing a remarkable change,” said Tuomas Lokki, Senior Vice-President of Planmeca. “A great deal has been done in Finland to promote innovation. One of our country’s main strengths is the active dialogue between companies, academia and the government. Healthcare technology has recently become Finland’s largest high-tech export, and we’re proud to be forerunners in the field,” Lokki stated.

The Royal Technology Mission visit was organised by the Royal Swedish Academy of Engineering Sciences. The academy has organised similar excursions around the world since 1984. In addition to His Majesty, the mission is formed by business executives and other influential figures from Sweden’s private and public sectors.
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Dr. Nikita Romashko - Chief Dental Advisor for the Department of Health Care and Doping Control of Sochi 2014

By Dental Tribune MEA

Dental Tribune MEA: Dr. Nikita, a pleasure to interview you. Could you introduce yourself to the readers of Dental Tribune and your experience as an Oral Surgeon?

Dr. Nikita Romashko: In the past century I graduated from the Moscow Medical Stomatological Institute - a leading dental school of the former USSR. Since then I have gone from intern to the head of a large dental clinic Rodenta in Moscow. Besides treating patients I did a lot of organizing work, collaborated with insurance and assistance companies and acted as a business development advisor.

You were the Chief Dental Advisor for the Department of Healthcare and Doping Control during the Sochi Olympics in Russia 2014. What responsibilities did this include and how did you manage the obligations?

Personally my role was to plan dental services during the preparation and coordination of its work. The event. Four years before the Games we started to develop the entire dental team we comprised the mission whilst receiving excellent feedback from athletes, team physicians and officials. It is a set of certain deeds, both professional and personal.

How did you manage the preventive measures you took during the Olympic Games?

Prevention - is a long process that cannot be implemented for 2 weeks. Our task was to show the importance of prevention to athletes. In London 2012 and Sochi 2014 Games an Athletes Survey was carried out supported by Procter & Gamble, which showed the athletes’ understanding of the importance of dental health and the link between oral health and training and performance results. Secondly, it was important to show in practice that prevention is not just an abstract concept, it is a set of certain deeds, both individually and dental professionals assisted, which does improve and maintain oral health. Athletes received welcome packs containing dental care products by Procter & Gamble, clinics had brushes and pastes, which were distributed among athletes. Besides the hygiene products, Procter & Gamble took care of the patient’s education by providing demonstration models for oral hygiene instructions and brochures about the main dental diseases. For me it is very encouraging that more than 100 athlete visits were exclusively related to professional hygiene and checkups.

What were the challenges and achievements during your experience in Sochi?

As I mentioned, we took care not only of athletes, but also the workforce. In fact, we had to take responsibility for more than 10,000 people - more or less the population of a small town. The number of visits was a record - 3 Olympic Villages separated from each other by dozens kilometers. Each village had its own clinic and each clinic had a dental department including 3 operatories in the coastal village, 2 - in the mountain village and 1 - in the endurance village.

“There were 3 Olympic Villages separated from each other by dozens kilometers. Each village had its own clinic and each clinic had a dental department including 3 operatories in the coastal village, 2 - in the mountain village and 1 - in the endurance village.”

What other partners did you work with who helped you achieve your goals in Sochi?

Sure! Olympic Games are a pact between the teams. We primarily took care of the number of visits were a record - 3 Olympic Villages separated from each other by dozens kilometers. Each village had its own clinic and each clinic had a dental department including 3 operatories in the coastal village, 2 - in the mountain village and 1 - in the endurance village. Procter & Gamble was not only subject to partnership agreements but a personal choice.

Going beyond the Olympic Games, has Sochi had an impact on you?

During the clinics equipping, we primarily took care of the quality and reliability of proven solutions the partners could offer. Therefore, a cooperation with Procter & Gamble was not only subject to partnership agreements but a personal choice.

What were the challenges and achievements during your experience in Sochi?

Personally my role was to plan dental services during the preparation and coordination of its work. Four years before the Games we started to develop the event. Four years before the Games we started to develop the event. Four years before the Games we started to develop the event. Four years before the Games we started to develop the event.
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- Clinically proven relief from the pain of sensitivity*1-4
- Gently lifts stains and help prevent new stains from forming5-7
- Ultra-low abrasive formulation appropriate for your patients with exposed dentine8

Recommend Sensodyne – specialist expertise for patients with dentine hypersensitivity

*With twice-daily brushing
Stannous Fluoride Dentifrice with Sodium Hexametaphosphate: Review of Laboratory, Clinical, and Practice-Based Data

By Cynthia Seneñahur, BDDH, BS; Mary Elizabeth Sager, BS, MA

Abstract
Dentifrice was originally used to promote oral hygiene by cleaning teeth. However, with advances in product formulation, it has become a valuable vehicle for the delivery of agents offering health and cosmetic benefits. Stannous fluoride, introduced in 1955 in dentifrice, is one of the longest established of such agents. The well-known anti-caries efficacy of stannous fluoride is based on its impact on the tooth surfaces and on its antibacterial activity. More recently, the demand for tooth whitening products has increased and sodium hexametaphosphate has been shown to be helpful in whitening surface stains and in controlling calculus. A dentifrice formulation which combines the benefits of stannous fluoride with those of sodium hexametaphosphate is now available. A review of the evidence shows that in addition to effective anti-caries action, this formulation is effective in fighting plaque, gingivitis, and gingival bleeding while inhibiting calculus and extrinsic stain.

A practice-based evaluation including data from over 1,200 dental professionals and 1,000 patients demonstrates the product's benefits and excellent acceptability. Collectively, the research shows this stannous fluoride/sodium hexametaphosphate dentifrice provides multiple benefits to meet the oral health and cosmetic needs of patients.

Key Words: stannous fluoride, dentifrice, gingivitis, caries, sensitivity, calculus

Introduction
Patients today represent one of the most heterogeneous groups in history in terms of age, health status, oral hygiene habits and other factors. While certain oral health conditions are more prevalent among specific patient groups, such as periodontal disease among diabetic patients, many oral health conditions affect the broad population. According to U.S. surveys, virtually all adults have had dental caries, more than half experience gingivitis, and roughly one in three suffer from dental sensitivity. Fortunately, home care products are available to help prevent and treat many common oral health conditions in conjunction with routine professional care.

Dentifrice is one important example. Many years ago, the benefits of dentifrice were limited to the prevention of the formation of the prevention of tooth decay. It was common for professionals to tell patients to “use any dentifrice with fluoride and the ADA Seal.” However, formulators today can design dentifrices to provide numerous other benefits, both for health and cosmetic purposes. In 2005, a stannous fluoride/sodium hexametaphosphate dentifrice was introduced offering protection against a broad range of health and cosmetic conditions commonly experienced by patients. The present review reports the laboratory, clinical and practice-based assessments evaluating the efficacy of this dentifrice formulation.

Stabilized stannous fluoride/sodium hexametaphosphate formulation
The SFSH formula combines the therapeutic benefits of 0.454% stabilized stannous fluoride with the calculus and stain-control characteristics of sodium hexametaphosphate in a low-water formulation dentifrice. Stannous fluoride, which unlike sodium fluoride can be used in combination with calcium-based abrasives, has been incorporated in dentifrices since the 1950s to provide protection against caries, pathogenic bacteria, gingivitis, hypersensitivity, and the development of plaque. There is considerable evidence for its efficacy as a therapeutic agent with a wide spectrum of beneficial properties. However, its clinical usage was limited because of an astringent taste and in some patients its use resulted in extrinsic staining of the teeth.

The resulting dentifrice has improved esthetic qualities over the original stannous fluoride formulation, and delivers a broad range of therapeutic and cosmetic benefits (Figure 1). The remainder of this paper provides a summary review of research on stannous fluoride, sodium hexametaphosphate dentifrices, and, especially, the unique SFSH formulation.

Figure 1. Benefits of stannous fluoride and sodium hexametaphosphate
• Anti-bacterial activity against species associated with plaque, gingivitis, cavities and malodor
• Reduces plaque
• Reduces gingival inflammation and bleeding
• Protects against hypersensitivity
• Prevents caries
• remineralizes enamel and protects against demineralization

Figure 2. Bacterial activity assessment 16 hours after exposure. Left: water control. Right: stannous fluoride/sodium hexametaphosphate dentifrice. Green stained cells are live microbial cells; red stained cells are dead cells (from Ramji et al).
Table 1. Long-term clinical trials examining the effect of stabilized stannous fluoride on reduction of plaque, gingivitis and gingival bleeding.

<table>
<thead>
<tr>
<th>Reference (18-21)</th>
<th>Age Group</th>
<th>Dose</th>
<th>Duration</th>
<th>Mode of Delivery</th>
<th>Treatment</th>
<th>% Reduction in Gingival Bleeding</th>
<th>% Reduction in Plaque</th>
<th>% Reduction in Gingivitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archila et al. (18)</td>
<td>168 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>6 months</td>
<td>6-months</td>
<td>25.8%*</td>
<td>*</td>
<td></td>
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<tr>
<td>Archila et al. (18)</td>
<td>38 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>12 weeks</td>
<td>12-weeks</td>
<td>24.3%*</td>
<td>*</td>
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<tr>
<td>Boyd et al. (22-24)</td>
<td>23 adolescents</td>
<td>0.4%</td>
<td>Brush-on gel</td>
<td>Twice daily</td>
<td>18 months</td>
<td>50%**</td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Reiswanger et al. (25)</td>
<td>38 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>6 months</td>
<td>6-months</td>
<td>9%**</td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Clarizio et al. (26)</td>
<td>28 adults</td>
<td>0.1%</td>
<td>Mouth rinse</td>
<td>Twice daily</td>
<td>3 weeks</td>
<td>28%**</td>
<td>**</td>
<td></td>
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<tr>
<td>Chitkew et al. (27)</td>
<td>26 adults</td>
<td>0.2%</td>
<td>Spray</td>
<td>Twice daily</td>
<td>3 weeks</td>
<td>48%*</td>
<td></td>
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</tr>
<tr>
<td>Mallatt et al. (28)</td>
<td>128 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>6 months</td>
<td>6-months</td>
<td>17%*</td>
<td></td>
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<tr>
<td>Mankodi et al. (29)</td>
<td>104 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>6 months</td>
<td>6-months</td>
<td>20%**</td>
<td>**</td>
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<tr>
<td>Blaauw et al. (30)</td>
<td>130 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>6 months</td>
<td>6-months</td>
<td>22%*</td>
<td></td>
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<tr>
<td>Perlman et al. (31)</td>
<td>154 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>6 months</td>
<td>6-months</td>
<td>21%*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finamore et al. (32)</td>
<td>31 adults, partial</td>
<td>0.4%</td>
<td>Brush-on gel</td>
<td>Twice daily</td>
<td>5 months</td>
<td>55%**</td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>Williams et al. (33)</td>
<td>112 adults</td>
<td>0.45%</td>
<td>Twice daily</td>
<td>6 months</td>
<td>6-months</td>
<td>22%**</td>
<td>**</td>
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</tbody>
</table>

All reductions are versus control except for Archila et al. (18) and Chitkew et al. (27) which are relative to baseline values.

*Significant difference for ablation level
**P < 0.05
ND = non-significant

28 Recent studies have evaluated the antimicrobial efficacy of stabilized stannous fluoride (SF3) dentifrice. One such six-month trial found statistical significance in the reduction of 22% in gingivitis, 57% less bleeding and 7% less plaque relative to a negative control. In a second six-month trial with 126 subjects, Mallatt et al. found a 17% reduction in gingivitis (p < 0.001), a 41% reduction in gingival bleeding (p < 0.001) and an 8% reduction in plaque (p = 0.01) with the SFSH dentifrice versus a negative control dentifrice. The SFSH dentifrice also demonstrated a 35% and 24% reduction in gingivitis (20%) and gingival bleeding (27%) relative to a triclosan/copolymer control. In a follow-up to this study, Archila et al. chose subjects who had used the triclosan/copolymer dentifrice twice a day but who had proved unresponsive to it, and still had high bleeding scores at the end of the six-month study period. After three months use of the SFSH dentifrice, significant reductions in gingivitis and gingival bleeding were achieved in all patients with gingival disease, the SFSH dentifrice can offer significant health benefits when compared to other dentifrices.

In a three-phase study involving use of digital plaque imaging analysis (Figure 5), White et al. investigated the long-term efficacy of the SF3 formula in the control of plaque.36 At Phase 1, subjects brushed twice daily using a standard sodium fluoride/triclosan dentifrice; in Phase 2 brushing frequency was reduced to once a day using the same dentifrice; in Phase 3 the daily brushing regimen was continued using the antimicrobial stannous fluoride/sodium hexametaphosphate parodontic gel. Most plaque cov- erage was 15% during Phase 1, increased to 18% in Phase 2, but significantly reduced to 4% in Phase 3 showing a 71% reduction as compared with the sodium fluoride/medium parodontic gel. This sup- ports the sustained antibacterial effects reported by Ramji et al.23

At 8 weeks, the SFSH showed improvements of 71% and 44% versus the negative control for tactile and thermal measurements, respectively. These studies support that the SFSH dentifrice shares the anti-plaque characteristics of previous stannous fluoride formul- ations.

Anti-caries effects

The anticaries effects of stannous fluoride have been recognized since the late 1960s. Many studies have investigated the possible role of stannous fluoride in the prevention of dental caries.23-34 Many studies have investigated the possible role of stannous fluoride in the prevention of dental caries.23-34

Figure 4: Left: Scanning electron microscopy images showing open tu- bules after treatment with a sodium fluoride toothpaste (left) and closed tubules after treatment with a SFSH dentifrice (right). From Baig and Hic.

Figure 3: Plaque imaging system.
HEALTHIER & STRONGER TEETH* STARTING FROM DAY 1

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*ON ENAMEL PLAQUE AND ENAMEL EROSION VS ORDINARY TOOTHPASTE

Toothpaste from the No.1 toothbrush brand used by dentists themselves worldwide
A series of in vitro studies evaluating the acceptance and potential of the SFSH formulation have been reported in one publication; 5-7,9-12 these studies are summarized. It has been shown that dentists and patients prefer a SFSH dentifrice, 5-6, and there is growing acceptance of personal oral hygiene routines. 7-9 The SFSH dentifrice has been shown to be safe and effective in clinical studies. 10-14 The effects of SFSH dentifrice have been studied in patients with various conditions, including plaque formation, gingival inflammation, and tooth sensitivity.

In reviewing these data, it appears that combining sodium hexametaphosphate with stannous fluoride is superior to stannous fluoride or sodium hexametaphosphate alone. 

Anticalculus Effects

Dental calculus results from the mineralization of bacterial plaque formed on the surfaces of teeth. Agents that inhibit plaque growth, particularly condensed phosphates, have been found to be particularly effective in the prevention of calculus development. In this class of phosphates, sodium hexametaphosphate has been shown to be particularly effective. In vitro studies by White et al. 17 have shown that sodium hexametaphosphate in aqueous solution or in a dentifrice 18 has been shown to be significantly greater than for a conventional anti-tartar dentifrice containing triclosan. 19 This finding has been supported by four 6-month clinical trials in which sodium hexametaphosphate produced significant reductions in calculus formation – whether combined with stannous fluoride or stannous fluoride – as compared to a regular sodium fluoride dentifrice or a triclosan/copolymer dentifrice. 20-22

A total of 866 subjects participated in the four clinical trials. Efficacy was assessed using a standard clinical method (Volpe-Efficacy was measured using a standard clinical method) and concluded that the addition of stannous fluoride as a multi-benefit dentifrice ingredient. 23 A total of 1078 questionnaires were returned by patients. Of these, 88% reported positive assessments of the SFSH dentifrice (Excellent/Very Good/Good) and two-thirds of all patients stated that they intended to continue to use the SFSH product; this percentage rose to 77% when patients reported noticeable improvements in their oral health. In terms of rating specific effects, roughly 9 out of 10 patients rated the product positively for “keeping mouth healthy,” “cleaning teeth thoroughly,” being a “non-irritant,” “making gums healthier” and “freshening breath” (Figure 6). Eighty-three percent of patients rated the SFSH product “Excellent/Very Good/Good.”

Practice-Based Evaluation


The full list of references is available from the publisher. 

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Extrinsic tooth discoloration, an updated review

By Dr. Kassim Cynthia DDS, DESCO, DDEBR, member of Esthetic and Restorative Dentistry - Saint Joseph University - Department of Periodontology, Dental Tribune - Lebanon Dental Association

A variety of colors can typically be seen in the tooth surface and from the gingival margin to the incisal edge of the tooth a gradation of the color is caused by different factors and the type of tooth structure is likely to cause an alteration in outward appearance of the tooth caused by changes of light transmitting and reflecting properties.

Some discolorations are located on the outer surface of the tooth structure, others are caused by extrinsic factors and some occur during tooth development and re-set in an alteration of the light transmitting properties of the tooth structures. Tooth discolorations are caused by many factors: medications, genetic defects, diseases, trauma, caries and normal aging processes are some examples. It is important to understand what staining is in order to properly treat it.

There are two types of tooth discoloration: extrinsic which affects external surfaces outside and intrinsic which affects the tooth from the inside.

Extrinsic discoloration lies on the tooth surface or in the acquired pellicle. The majority of tooth discolorations are extrinsic in nature and appear as brown integuments. Chemical alteration is usually found on surfaces with poor tooth brushing accessibility. Smoking, tea or coffee consumption and increasing age are promoting factors and such discolorations are frequently seen in connection with oral use of antibacterial plaque-inhibiting mouthrinses. Chemical alteration of the acquired pellicle appears to be the major reason for these brown integuments.1

The causes of extrinsic staining can be divided into two categories; those compounds which are incorporated into the pellicle and produce a stain as a result of their basic color and those which lead to staining caused by chemical interaction at the tooth surface.2,3

Direct staining has a multi-factorial etiology with chromogens derived from dietary sources or substances habitually placed in the mouth. The staining chromogens are taken up by the pellicle and the color imparted is determined by the surface color of the chromogen. The origin of the stain may be metallic or non-metallic.4

The aim of this review is to systematize the literature for data concerning extrinsic tooth discoloration etiologies in order to establish the right treatment plan.

1 - Tobacco

For ages, tobacco has been popular and its use is significantly increasing despite of alarming health hazards. Smoking and chewing (chewing of betel, naswar, betel quid, betel nut, Pan) is known to cause staining.5 Smoking leads to not only tobacco and nicotine but other components from smoke and it also leads to gum disease and oral cancer.6 There are all kinds of smoking and smoking habits, including cigarettes, tobacco, nicotine and tar that can harm gum tissue and the mouth, besides they are reservoirs of periodontal diseases and infections. This is true of cigarettes, for which tar and crevices of teeth are mainly stained.7

According to Pirolo, the exposure to coffee after bleaching causes less color changes than the exposure to tea.8

A study evaluated the colour stability of three laminate veneer materials with tea, coffee and cigarette. It was found that cigarette smoke was the most staining agent.9

The aim of an in vitro study done by Yousak, Y et al was to compare the color stability of commercially available denture teeth. A total of 96 stained filtered coffee solution was found to be more chromogenic than the tea, and cola staining solutions.10

b - Tea

Tea, the commonly consumed beverage, is gaining increased attention in promoting overall health. In specific, green tea is considered a healthful beverage due to the biological activity of polyphenols.11-14 There are three main varieties of tea - green, black, and oolong, all derived from the leaves of the C. sinensis plant. The difference between the various teas lies in their processing. Green tea is prepared from unfermented leaves, the oolong tea leaves are partially fermented, and black tea is fully fermented.15

Lee et al have shown that the addition of milk to tea significantly reduces the tea’s ability to stain tooth enamel, which was determined to be the component of milk that is responsible for preventing tea-induced staining of teeth to a similar order of magnitude that can be obtained by vital bleaching treatments.16

Bovine and human enamel substrates behaved similarly in terms of staining and bleaching effects, although they presented inherent differences in color.17

A study has examined the surface staining mechanism of a photo-polymerized composite by coffee, oolong tea, and red wine.18 Dental composite was subjected to an experimental 24-hour staining cycle: 17-hour immersion in artificial saliva solution containing chromogens for 24h followed by 7-hour immersion in coffee, tea, or wine. Wine caused the most severe staining, followed by tea and coffee. Chlorogenic acid increased the staining effect of tea and coffee when compared to the control specimens. Common drinks stained the dental composite, but each at a specific mechanism that depended on external conditions such as the presence of chloroform.19

High content of tannins in tea causes staining.20

A research aimed to investigate bleaching enamel susceptibility to coffee and red wine staining at different time periods after bleaching. No differences were observed between the exposure times of 30 and 150 min after bleaching for both beverages (p > 0.05). Although coffee did not stain the surface, red wine significantly increased the previously bleached enamel.21

Atia et al have quantified the change in color of human and bovine teeth exposed to a coffee solution containing caffeine (2% and 5% caffeine) and barium permanganate (16% CP) home application bleaching treatment for 12 weeks.22 When the teeth were exposed to a coffee solution during home bleaching, the outcome of the bleaching effect was observed to be less stable (P < 0.05).

Bovine and human enamel substrates behaved similarly in terms of staining and bleaching effects, although they presented inherent differences in color.23

Teeth discolorations are associated with many clinical and estheticial challenges. They can have an impact on a person’s self-esteem and an emotional state in today’s society, where most people place tooth color high. The majority of cases of discoloration of the cause of discoloration is important as it has a profound effect on treatment outcomes.

Normal enamel is colorless and translucent. The color of the dentin is mainly responsible for the color of the tooth. The dentin has a yellow color where it consists of thick layers and where the enamel layer is thin (cervical margin).
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Other articles found greater enamel dissolution occurring in flavored and energy (sports) drinks than in cola drinks. Although a new article found no significant differences in the frequency of the consumption of foods and beverages and the presence of dental erosion.

d - Cola Drinks
Dark-colored colas not only stain teeth, but also erode tooth enamel and cause tooth decay, although a new article found no significant differences in terms of staining them. Cranberry juice, grape juice and other dark-colored fruit juices are very good at staining teeth because they contain pigments—and lots of them—that can yellow teeth, probably the same way they stain composite resin.

Cranberry juice is a rich source of polyphenols and other natural substances that can inhibit the growth of oral bacteria and prevent the formation of biofilms. The polyphenols of cranberries interfere with the growth of many types of bacteria, including those that cause tooth decay and gum disease. Additionally, cranberries are high in antioxidants, which have been shown to help reduce the risk of certain types of cancer.

The polyphenols of cranberries also have anti-inflammatory properties, which can help reduce swelling and inflammation in the mouth. They also help reduce bacterial growth and prevent tooth decay. Additionally, cranberries are a source of vitamin C, which is important for maintaining healthy gums and teeth.

In summary, cranberry juice is a good source of polyphenols and other beneficial compounds that can help prevent tooth decay and gum disease. It is recommended to drink cranberry juice regularly as part of a healthy diet to maintain healthy teeth and gums.

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Lycopene is a micronutrient with important health benefits, because it contains natural antioxidants like phenols, hydroxycinnamoyl and catechin, which have been shown to have potent antioxidant activity.

The tomato sauce is highly acidic and can attach to the teeth and cause unsightly stains.

i - Berries
Berries are a rich source of polyphenols and other natural substances that can help prevent tooth decay and gum disease. They are particularly good at staining teeth because they contain pigments and other compounds that can adhere to the tooth surface. Berries are a common cause of tooth staining, particularly in people who are heavy drinkers of wine or other alcoholic beverages.

In summary, Berries are a source of polyphenols and other beneficial compounds that can help prevent tooth decay and gum disease. It is recommended to avoid eating or drinking Berries if you have a history of tooth staining or if you are concerned about the appearance of your teeth.

The information provided is based on scientific research and clinical studies. It is important to consult with a dentist or other healthcare professional for advice on the best way to maintain healthy teeth and gums.

Thus, balsamic vinegar is a uniquely tasting herb derivative found to be effective in reducing stress, increasing the expression of pro-inflammatory genes in vitro and current evidences are promising concerning the role of berry (poly) phenols to support cardiovascular health.

Even if the deep berry blue color can cause deep staining, aren’t all the benefits cited above worth staining teeth?

3 - Betel leaf
India, Pakistan
The betel (Piper betle or Paan) is the leaf of a vine belonging to the Piperaceae family, which includes pepper and kava. Explored for their unique medicinal properties, the leaves of Piper betel, an evergreen perennial vine, are a reservoir of phenolics with antimutagenic, antitumour and antinociceptive activities. It is a compound of natural substances chewed for its psychostimulat- ing effects. Studies showed that oral feeding of betel leaf extract (BLE) significantly inhibited the growth of human prostate. It is believed that chewing betel quid could reduce stress, strengthens teeth and maintain oral hygiene.

Approximately 200 million persons chew betel regularly throughout the western Pacific basin and south Asia. There is copious production of a blood-red saliva that can stain oral structures. After years of chewing, the teeth may become red to nearly black.

4 - Liquorice
It is a uniquely tasting herb derived from Glycyrrhiza glabra, and has been used in medicine
Conservative Care and Treatment of TMJ Dysfunction in Dental Patients

By Shivani Sarthi, Physical Therapist (TMJ Specialist)

Each year, the number of reported cases of TMJ dysfunction patients increases in the United States. It is often due to stress, trauma to the jaw, post-dental procedures, or other factors. For TMJ sufferers, TMJ dysfunction is defined as a term covering disorders affecting the muscles of mastication and the temporomandibular joints.

The symptomatic picture of a TMJ patient does vary significantly from one individual to another. In general, patients will complain of malocclusion, joint pain, joint sounds, and pain radiating to the face. Recent studies show that more females than males suffer from TMJ symptoms, most of which are in their childbearing years.

The conventional methods used to treat TMJ dysfunction include: Botox to relax specific muscles, exercise, education, orthodontics (braces, retainers, mouth guards), and some surgical techniques. There exist options in the field of physical therapy for patients looking for an alternative health approach. Specialized treatment programs are specific to release and joint mobilization, alone, has had a profound affect on the results of TMJ suffers. Application of intra-oral technique to release the lateral pterygoid myofascial release to the anterior temporalis muscle pain and weakness.

For the treatment of brachial asthma, the root of liquorice (Glycyrrhiza glabra) has been used as a traditional medicine in the East and West. Licorice (Glycyrrhiza) A is the predominant, characteris- tic chalcone in liquorice root which might be involved in the patho-genesis of virus-exacerbated ed asthma.

Liquorice is used as a flavorant in a variety of edibles, medi- cine, and tobacco, and is often innocently consumed in vast amounts without any regard or knowledge that it can cause damage to the tongue and teeth. Glycyrrhizin (GL) is a major component of Glycyrrhiza, and in moderation on their own contains a singular liquorice flavour. The root is used in confections and from liquoric- black liquorice is known, but the true splendor side of teeth prone to accumulate dental staining but also the muco-gingival structures specific changes. Gingival re-gional side of teeth prone to accumu- late common darkening agents such as tobacco and alcohol. Heavy tobacco dental staining can be noticed from pipe smok- ing with Liquorice as an additive. Tobacco can release and contribute to tooth and tongue staining, especially when included in aromatic pipe tobac- co, liquorice additives enhance the pro- longed flavor of the chewing tobacco experience, and consequently damage from longer contact time onto the gingiva, seeming to derive more from tobacco products than just liquorice. Adjacent re- duction, cervical dentinal stain- ing, and thickening with hyper- keratinous of mucosa are seen.

Recently liquorice is mixed with dark caramel and food dyeings which leave a surface brownish/black tongue stain. This tongue stain is water solu- ble and usually disappears after a few hours.

Health care workers, including all in the dental team, discover- ing new hypochlorite products, are promoting, pleasurable to eat, and in moderation on their own range of foods. The use of extracellular polysaccharides from microbial activity contributes to biofilm formation and bacterial plaques. This allows for a tacky gummy surface of muco-poly saccharides to stick to stagnant areas on teeth, and with adherent endogenous bacteria, liquorice tobacco products discolor teeth and acceler- ate adjacent gingival break- down. Qutting the tobacco habit with safe tooth removal through scaling and polishing from teeth is feasible.

Heavy tobacco dental staining can be noticed from pipe smok- ing with Liquorice as an additive. Tobacco can release and contribute to tooth and tongue staining, especially when included in aromatic pipe tobac- co, liquorice additives enhance the pro- longed flavor of the chewing tobacco experience, and consequently damage from longer contact time onto the gingiva, seeming to derive more from tobacco products than just liquorice. Adjacent re- duction, cervical dentinal stain- ing, and thickening with hyper- keratinous of mucosa are seen.

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Chewing tobacco is known to cause staining, and therefore, may promote bruixism at night. Bruixism, is a neurologic, sleep movement disorder characterized by grind- ing or clenching of the teeth in our sleep. This disorder is very damaging to the teeth and the temporomandibular joint, and also causes fatigue and pain to the facial mus- cles. Lifestyle changes and sleep hygiene techniques can be re- forced by the physical therapist, to help maintain optimal TMJ function and help manage pain and discomfort.

Treatment and management of TMJ is a joint effort between pa- tients, dentists, and therapists. It can and should be effectively treated through specialized physical therapy modalities, and inextr- o-dental stain accumulation after six weeks, with increased accumu- lation after 12 weeks versus brushing alone.

Poliynlyrrolidone (PVP) (a polymer used as a synthetic blood plasma substitute and in the cosmetic, drug, and food- processing industries) was shown in vitro to reduce chlo- hexidine induced, dietary stain- ing without affecting the uptake of the anesthetic to the test sub- strate. A study in vivo aimed to determine whether PVP or chlorhexidine, or a combination of both, could be applied to stain- ing found with polyvalent met- als. The characterising strength of the tongue and teeth noted by Flotra is not peculiar to chlorhexidine, it has been reported in other cationic antiseptic- s, an essential oil/phenoilic mouthrinses, following prolonged use of delominopal mouthrinses. There is great indi- vidual variation in the degree of staining from person to person, this makes explanation more difficult. It is often caused by intrinsic factors, differences in extrinsic factors or both. Bock suggests that the protein and carbohydrate in the acquired pellicle could undergo a series of condensation and polymeriza- tion reactions leading to discolor- ation of the acquired pellicle. Chlorhexidine may accelerate formation of the acquired pelli- ce and also catalyze steps in the Maalard reaction.

The results of a recent study demonstrated that regular use of CPH and chlorhexidine mouthrinses reduced the stain accumulation after six weeks, with increased accumu- lation after 12 weeks versus brushing alone.

The study tested, reduced the stain propensity of a 0.05% chlorhexidine rinse. Tooth stain intensity was significantly in- creased with 0.06% chlorhex- idine rinses compared to placebo and chlorhexidine/PVP rinses, PVP, at the concentra- tions tested, reduced the stain propensity of a 0.06% chlorhex- idine rinse but at the expense of some loss of plaque inhibition.

Adly et al wanted to determine whether a co-polymer anti- adhesive agent would prevent or reduce the formation of chlorhexidine induced, dietary stain- ing. A study of the antiseptic to the test sub- strate. A study in vivo aimed to determine whether PVP or chlorhexidine, or a combination of both, could be applied to stain- ing found with polyvalent met- als. The characterising strength of the tongue and teeth noted by Flotra is not peculiar to chlorhexidine, it has been reported in other cationic antiseptic- s, an essential oil/phenoilic mouthrinses, following prolonged use of delominopal mouthrinses. There is great indi- vidual variation in the degree of staining from person to person, this makes explanation more difficult. It is often caused by intrinsic factors, differences in extrinsic factors or both. Bock suggests that the protein and carbohydrate in the acquired pellicle could undergo a series of condensation and polymeriza- tion reactions leading to discolor- ation of the acquired pellicle. Chlorhexidine may accelerate formation of the acquired pelli- ce and also catalyze steps in the Maalard reaction.

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cantly increased compared to the other 3 rinses. The antia-
hesive/chlorhexidine rinse pro-
duced the most significant decrease in the anti-
hesive or water rinse.

However, the paralleled plaque re-
growth study suggested this inhi-
bition of staining resulted from the plaque removal activity by the anti-adhesive.

The quality of the consumed drinking water may also affect oral health. For example, the poisonous iron, copper and zinc in drinking water can cause extrinsic discolorations.

As known, Cationic antiseptics such as chlorhexidine (CHX) and cetylpyridinium chloride (CPC) are used to encourage biofilm reduc-
tion to promote oral health. It has been shown to be effective against Actinomyces and other microorganisms. It is an antiseptic that kills bac-
teria and other microorganisms. It can be used in preventing dental plaque and reducing gingivitis.

It has also been shown to be useful in certain pesticides. Cetylpyridinium chloride may cause brown stains between the teeth and on their surfaces. However, these stains can be easily removed by brushing and cleaning during a routine check up.

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How-
The image contains information about World Oral Health Day on March 20, 2015. It encourages people to smile for life. The website worldoralhealthday.org and the hashtag #WOHD15 are also mentioned.
Firsthand Experience With Polychromatic LS2 ingot... IPS e.max Multi... because it works

By Alham Farah

Polychromatic lithium disilicate pressing ingot—IPS e.max Press Multi. The 400MPa ingots feature a gradu-ated level of shade and translucency, with chroma and opacity higher in the cervical and dentin regions, and more translucency in the incisal areas.

Here under I am sharing with you my firsthand experience on this ingot, from a material and technology point of view, before deciding whether it's your ma-terial of choice to use in a real clinical case or not, you need to experiment the optical proper-ties, and learn how to handle the masking, shade matching and color dimensions, and how to get the best esthetic results out of it.

Here I decided to choose a unique feminine smile of hol-lowed celebrity (Imogen poots), and try to mimic it using a combi-nation of our new IPS e.max press Multi ingot BL2 (for cen-trals & Laterals) AND the tradi-tional IPS e.max press ingot LT BL2 (for Canines and 1st premolars).

Horizontal sprueing technique - From a (Mesial-Distal) angle of view.
We align the more narrow side of the Wax Pattern Sprue with the occlusal or incisal area of the waxup. For the labial surface of our wax restoration to be al-ways parallel to the Wax pattern Sprue surface, so the ceramic flow path is not directed toward the die. This eliminates lateral pressure on the investment die.

- From a (Labial) angle of view.
We Align our wax restoration vertically with the center of the Wax Pattern Sprue. The long axis of the Wax Pattern Sprue to be parallal to the long axis of the restoration; this way, the materi-al layers (Dentin-Incisal) main-tain their horizontal relationship during pressing. (Fig 3a.)

Controlling translucency ratio
The ability to manipulate the sprued restoration on the sprue base is a fabulous option to con-trol translucency level. If more translucency is desired, the res-toration and Wax Pattern may be lowered by up to 2mm Max, by cutting a small notch from the wax pattern, in order to reach more incisal portion from the ingot to the pressed restoration. (Fig 4.)

From the natural teeth in the picture we notice high level of translucency in the incisal third of the two centrals which do not exists in the two laterals, what required lowering the position of the centrals so more incisal layer will reach the pressed res-toration from the Multi ingot, however the positioning for the two laterals kept the same ac-cording to the instruction for use for pressing IPS e.max Multi from Ivoclar Vivadent. (Fig 6.)

Canines and 1st premolars were sprued vertically in the tradi-tional way of spruing the IPS e.max press and prepared in another ring base to be pressed later. (Fig 7.)

In a close comparison between the conventional IPS e.max Press (low translucency) ingot and IPS e.max Press Multi, I no-ticed the following remarks:
1. The dentine layer exists in the Multi is equivalent to the one in LT ingot, maybe the masking ca-pability is even a little better, es-pecially after testing the centrals on ND1 & ND2, they maintained the same shade brightness they have in BL2 shade tap with no ND influence. (Fig 11.)
2. The thickness played an im-potent role in boosting the brightness level and positioning the final shade in between the BL2 & BL1. (Fig.11.)
3. The incisal layer exists in the

> Page 2C
Modern zirconium oxides fulfil three major requirements of contemporary dental technology: high strength, esthetics and efficiency. The author describes the fabrication of monolithic posterior tooth restorations with the translucent zirconium oxide Zenostar Zr Translucent.

By Dieter Knappe

This article is written in celebration of zirconium oxide, a material which has firmly established itself in the dental laboratory over the past 15 years or so. If appropriately used, zirconium oxide restorations produce very strong and durable results. They also satisfy demanding esthetic requirements due to their translucent properties. The following case study shows how monolithic zirconium oxide is effectively incorporated into the digital manufacturing chain to produce highly esthetic and effective dental restorations without having to compromise on esthetics. In the presented case, a wax-up was crafted which served as a basis for fabricating a provisional restoration (Tetric® CAD for Zenotec; Wieland Dental) and a permanent restoration (Zenostar Zr Translucent, Wieland Dental) with one digital data set and CAD/CAM milling equipment.

Preoperative situation

The patient presented to the dental practice with a fractured ceramic inlay restoration in tooth 26 which she wished to have replaced. The tooth had been restored many years previously. Since tooth 25 and tooth 55 were discoloured as a result of a root canal treatment, they were included in the treatment plan. The existing tooth structure of tooth 26, which had been prepared to accommodate the inlay in the past, was preserved to the best possible extent. The patient had very high esthetic expectations and wanted the explicit assurance that the crowns would look completely natural. Nonetheless, we decided to use a very efficient fabrication method in which monolithic restorations are produced with translucent zirconium oxide (Zenostar Zr Translucent). Three options are available for fabricating monolithic restorations with this approach:

1. milling, sintering, glazing (efficient, cost-effective);
2. milling, sintering, individualization with ceramic characterization materials, glazing;
3. milling, individualization with infiltration liquids, sintering, glazing (highly esthetic).

We chose to pursue the third method, which would be very cost-effective as a result of the benefits offered by the digital workflow.

Advanced zirconium oxide

Zirconium oxide is more than twice as strong as other dental ceramics, and it exhibits excellent mechanical properties. Due to its translucent characteristics, the material has been fulfilling highly esthetic requirements for quite some time now. The material is used to fabricate full-contour (monolithic) restorations and frameworks that provide a base for individualized veneers. The zirconium oxide material Zenostar Zr Translucent shows excellent light transmission. In this system, efficiency teams up with esthetics to offer impressive results. The wide range of discs, the matching stains and the brush-infiltration technique allow different effects to be imparted to restorations in a relatively short time.

Preparation

The following aspects were paramount in preparing teeth 25, 55 and 26 for the ceramic restorations: avoidance of sharp edges and observation of a minimum wall thickness. The benefits of using zirconium oxide include the material’s high strength and as a consequence, the fact that little tooth structure needs to be removed. The cavity in tooth 26 already showed extensive preparation. However, in order to properly anchor the new restoration, pre-preparation was shown to be inevitable. The cavity had to be extended towards the buccal aspect. Despite being very thin, the buccal cusp walls were in an acceptable condition.

Fabrication of long-term temporaries

According to the treatment plan, the patient would have to wear long-term temporaries for a period of several months. In order to fabricate these restorations, a crown. Following the preparation phase, impressions were taken of the upper and lower jaws and the occlusal relationship was established. Then, the clinician fabricated the provisional restorations with the help of a customized tray.

Conclusion

Ivoclar Vivadent’s new IPS e.max Press Multi is a real innovation in the pressing technology pyramid, for fabricating esthetic and multi-dimensional monolithic restorations without putty back or layering in most of the cases, because esthetic results are achieved in a single press sequence with subsequent glazing. The ingots feature a graduated level of shade and translucency similar to that of natural teeth. With a strength of 400 MPa, the material is indicated for anterior and posterior crowns, veneers and hybrid abutment crowns. The ingots are available in one size and in the following shades: A1, A2, A3, A3.5, B1, B2, C1, C2, D3 and BL2.

I advice using this solution for upper and lower centrals and laterals, where translucency level and esthetics is higher, but strictly when the labial preparation thickness is 1 mm and up, for the graduated level of shade and translucency in the ingot to be visible. I was intuitive to try the bleach shade out of the full shade range intentionally, because I believe this ingot will solve the grayish problem generated by layering enamel powder on any bleach color. And it really worked.

Contact Information

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Microcracks are prevented by reducing the grinding work to a minimum.

At this stage — before the staining materials were applied — the zirconium oxide crowns were polished and the surfaces were smoothed (Fig. 12). This effectively counteracted the common concern of abrasion.

Before the crowns were fired, a glaze (Zenostar Magic Glaze, Wieland Dental) was sprayed on their surfaces in order to establish an even base for the application of the staining materials. Stains in paste form (Zenostar Art Module Pastes, Wieland Dental) were used to characterize the restorations. The pastes had to be mixed to a soft, smooth consistency before they could be applied. The cervical and incisal areas of the restorations were individualized with the stains (Fig. 15). A film of glaze was sprayed on the restorations (Fig. 14) before they were fired.

The combination of the stains and the lightly fluorescent spray glaze produced a three-dimensional effect.

After the final firing, the crowns did not appear any different from layered restorations. On the contrary, they looked very life-like and showed a natural internal play of colour. In the next step, the occlusal contacts were checked in the articulator and the proximal contacts on the model. Then the crowns were sent to the dental practice for placement.

Seating of the restorations

Teeth 25, 35 and 26 were suitably adjusted and the remaining occlusal wear was removed. Right from the beginning, we were aware of the concern of abrasion. Therefore, the internal play of colour had to be reduced by the finishing work to a minimum. But the long-term temporary crowns could not be preserved. Consequently, the long-term temporary crowns were re-seated and a new treatment plan was presented to the patient for tooth 26 on the basis of a detailed analysis. A few weeks later, the permanent all-ceramic crowns were cemented (SpreiCEMB®) on tooth 25 and tooth 35. The plan was to replace tooth 26 with an implant-supported restoration at a later date.

Conclusion

The monolithic zirconium oxide crowns on tooth 25 and tooth 35 were indiscernible from the other teeth (Figs 15 and 16). The patient reported that she was able to chew comfortably and naturally. The CAD/CAM fabrication protocol allowed the crowns to be cost-effectively produced. The translucent material (Zenostar Zr Translucent) that was used in this case showed a high level of light transmission. Therefore, it offered the ideal basis for reproducing the optical properties of the natural teeth. The described approach will help to satisfy the rising number of esthetically discerning patients, since it offers an attractive alternative to individually layered ceramic crowns and cast crowns made of precious or non-precious metal.
inLab MC X5: Open 5-axis production unit for dental laboratories

By Sirona

inLab MC X5, the five-axis milling and grinding unit was newly developed especially for the demands of dental laboratories, completes Sirona’s inLab system. Dental technicians benefit from the greatest flexibility for the entire production process of esthetically pleasing restorations and the largest selection of materials available on the market.

Developed especially for dental laboratories

“...the new laboratory unit sends a clear signal from Sirona to dental technicians,” says Reinhard Pieper, Director of inLab Product Management at Sirona. Users benefit from 30 years of experience with CAD/CAM in wet processing of various materials combined with new dry processing techniques – in one machine. “We implemented all of our know-how as a pioneer and innovation leader of dental CAD/CAM technology to develop a CAD/CAM laboratory machine tailored specifically to meet existing and future demands,” added Pieper. “This ensures that inLab MC X5 will be a good investment in the long term.”
inLab MC X5 is Sirona’s first open production unit and is suitable for use with various existing CAD/CAM equipment in dental laboratories – for users with a Sirona scanner and inLab software or for laboratories with scanners and CAD components from other manufacturers. STL restoration data can be imported easily and quickly to the CAM software module developed for inLab MC X5 and processed with inLab MC X5. In combination with the inEos X5 scanner and inLab software, the new laboratory machine is the optimal complete solution for new users of Sirona CAD/CAM production.

Productive laboratory unit for all common processing jobs

Depending on the indication and material, the five-axis inLab MC X5 can be used for wet or dry processing. In addition, for the first time it is possible to switch automatically from dry to wet processing when working on one part. Tools used include carbide cutters and diamond grinders as well as standardized disks with a diameter of 98.5 millimeters and a height of up to 50 millimeters. Users can ensure efficient utilization of material by using the disk management function and extensive nesting functions. The specially developed multi-block holder uses CAD/CAM materials in block form. It can be loaded with up to six blocks of different materials at the same time.
inLab MC X5 is thus designed to be a universal laboratory unit for a number of indications and for processing various oxides, polymers, composites, wax, glass ceramics, hybrid ceramics, and prepared for metals. The machine allows the laboratory a free choice of all material suppliers and it benefits additionally from the material competence of Sirona’s material partners VITA Zahnfabrik, Ivoclar Vivadent, Dentply, Merz Dental, 3M ESPE, and GC.

Open, user friendly, and cost effective

Thanks to the combination of the wide range of indications, free choice of materials, and open interfaces for external restoration data, dental technicians can use the machine flexibly from the start. The high-quality, functional design of the chamber of the la-boratory unit ensures easy maintenance and makes it fast and easy to clean with the specially developed “easy-clean” concept. It can quickly switch among various materials and between wet and dry processing. This flexibility combined with the reasonable cost and the fact that there are no additional dongle fees makes inLab MC X5 very cost effective. The unit is delivered with its own inLab CAM software module and can be ordered from dental dealers immediately.
2005–2015: CAPP celebrates ten years of successful continuing dental education

By Dr. Dobrina Mollova

Dubai, UAE: May 2015 will mark a significant milestone in the history of the Centre for Advanced Professional Practices (CAPP) in Dubai. CAPP will be celebrating its tenth anniversary of successful continuing dental education not only in the United Arab Emirates but also across the Middle East. Through the hard work of its colleagues, sponsors, partners and supporters, CAPP has been able to establish first-class standards for continuing dental education programmes over the past decade. Participants and followers of CAPP programmes have also helped develop professional training according to the needs of the region with their open feedback.

CAPP is an ADA CERP-recognised provider that specialises in continuing medical and dental education programmes (conferences, hands-on courses, workshops and self-instruction programmes). For the past ten years, CAPP has facilitated over 500 continuing education programmes with over 52,000 international participants. With the opening of CAPP Asia in 2012, CAPP’s reach has expanded to the Asia Pacific region and beyond.

In 2012, CAPP joined the global family of 96 publishers by becoming the proud owner of the Dental Tribune Middle East & Africa edition, and has since been delivering six print editions annually to over 20,000 dental professionals in the Middle East and Africa region, and has delivered 24 newsletters to more than 41,000 active subscribers. Through its international website, the latest industry news reaches the largest dental community worldwide—an audience of over 650,000 dentists.

CAPP started out in Dubai ten years ago as a centre for professional training. It quickly grew and developed two very important international conferences: the CAD/CAM and Digital Dentistry International Conference and the Dental-Facial Cosmetic International Conference.

Next year, the tenth CAD/CAM and Digital Dentistry International Conference will be celebrated together with the CAPP anniversary. The last decade has been a journey with challenges in keeping pace with the incredibly fast growth of the industry combined with new technologies, particularly in digital dentistry.

Ten years ago, it would have been difficult to imagine the kind of opportunities presently available to change dentistry and improve overall patient care, including diagnostics, planning and treatment, in terms of precision, treatment and healing time, and aesthetics.

What has been accomplished in the past ten years has been significant and CAPP would like to thank all of its business partners, sponsors and supporters for together making CAPP the success it is today. CAPP would especially like to acknowledge all who have worked at and continue to be with the CAPP office and share the challenges and passion. Thanks also go to all of the dentists, dental technicians, dental hygienists and dental assistants who have followed us in the decade of rapid development of the dental industry and dental technology.

Book your luxury stay at Jumeirah Beach Hotel Dubai together with the CAD/CAM & Digital Dentistry International Conference on 08 - 09 May 2015 and enjoy our CAPP corporate rate.

While you are at the Conference, discover Jumeirah Beach Hotel’s services and facilities for the whole family at Dubai’s finest beach hotel. Enjoy spectacular views of the Arabian Gulf.

At the Conference we consider every moment another chance to satisfy your needs for continuing dental education and for leisure. Enjoy one of our guest packages for you and your family, which lets you be you.

We are looking forward to welcoming you to the truly unique beach resort.

Thank you all very much for your support and loyalty year after year. This year marks the 10th anniversary of our conference. What starts as a simple idea 10 years ago proved, without any doubt, to be a success beyond compare.

Our societies are becoming more and more dependent on technology and what it can offer to make our lives easier and more enjoyable. Dentistry is no exception. Our patients are all the way different than they used to be a couple of decades ago. They have unrestricted easy access to knowledge through the web. They are becoming more and more demanding in terms of services that we provide as well as the technology we employ to do so.

“Do you provide CEREC restorations in your office”. “Does this office use Zirconia and Emax for crowns and veneers”. “Are you Doc in CAD/CAM technology”. These are quite common questions our patients usually ask nowadays. Questions that are very hard to answer unless we are really involved in this fast moving technology. This is precisely the importance of our conferences.

Our team of Organizers, Sponsors, as well as Speakers will continue our quest to keep all of you well ahead and updated in all fields of CAD/CAM and Digital Dentistry.

Dr. Munir Silwadi, BDS, MRCDS(E), DUSS, FADI, FICD
Conference Chairman & Scientific Program Advisor

Hands-On Courses

**DR. MUNIR SILWADI, CANADA**

Indirect Inlays, Onlays & Partial Crowns
07 May 2015

Indirect Veneers
10 May 2015

**DR. EDUARDO MAHN, CHILE**

Advanced Anterior Composite (Direct Veneer and Diastema Closure)
06 May 2015

Non-Prep Veneers and Modified Non-Prep Veneers
07 May 2015

Emergency Profile, Tibases, Abutment Selection and Proper Temporization
08 May 2015

iPhone Photography
09 May 2015

Biological Preparations for CAD/CAM and Non CAD/CAM Restorations
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**DR. HARALD HUSKENS**

Bone or Tissue - What’s the Issue?
09 May 2015

**DENTISTRY AWARD**

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Dr. Andy Wallace, UK
Dr. Gary Pearson, AAI, UK
Dr. Richard Field, UK
Dr. James Lozada, AAI, USA
Dr. Jens Nohe, Germany
Dr. Guido Kisters, Germany
Dr. Shankar Iyer, USA

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Interceptive Ocularal Dentistry - the new path for dentistry
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Why EVERY dentist should offer simple orthodontics!
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Essential Dental Photography - made exquisite
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DR. EDUARDO MAHN, CHILE

Veneers Vs Crowns: the Challenge in Smile Design
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Direct Veneers: the Shades Dilemma
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Inman Aligner Trainers Course
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CAPP

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MARY ROSE BOGLIONE

Periodontal Instrumentation
14 November 2015

AAID

AAID Hands On Courses
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DR. MUNIR SILAVADI, CANADA

Indirect Veneers
12 November 2015

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IA ANNUAL SYMPOSIUM

Inman Aligner and Intelligent Alignment Systems are pleased to announce our annual symposium. Following a superb 2014 meeting in Copenhagen our 2015 venue is DUBAI! We have a world renowned line-up of speakers.

We have secured fantastic room rates at the exclusive Jumeirah Beach Hotel during peak season.

Only:
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We are also pleased to share the venue in a joint meeting with the 7th Dental - Facial Cosmetic International Conference (DF-CIC) so those wanting to combine some winter sun with even more superb CPD can combine both meetings.

To secure accommodation visit: www.cappmea.com/aesthetic2015/accommodation.html

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In 2012 CAPP joined a global family of 95 publishers by becoming the proud owner of the Dental Tribune Middle East & Africa edition, and since then we have been delivering 6 print publications to over 20,000 Dental Professionals and in the MEA region, 24 e-newsletters are delivered to more than 41,000 active subscribers, and through an international website the latest industry news reaches the largest dental community worldwide wide an audience of over 650,000 Dental Tribune readers.
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