Over 100 countries celebrate World Oral Health Day

By Dental Tribune International

Geneva, Switzerland: World Oral Health Day (WOHD), which takes place annually on 20 March, inspired many national dental associations, dental students and other participants around the globe this year to organise a wide range of awareness-raising activities. According to the FDI World Dental Federation, reports are only just coming in from around the world and signs are that the event has exceeded expectations.

Over 300 students gathered in Amsterdam in the Netherlands for the second edition of the ToothCamp, a theatrical informational event that seeks to educate children and adolescents about dental issues. The participants were able to try out dental tools, as well as learn more about the benefits of eating healthily and about the importance of optimal oral health through exciting chemical experiments with acid and lime or porcelain and abrasives under the supervision of biology, chemistry and physics experts.

Hong Kong's Department of Health organised an oral health carnival, which attracted an audience of about 2,300 local citizens. Through interactive games, exhibitions on oral health information and teeth-cleaning demonstrations, the public were reminded of the importance of taking care of one's oral health from an early age by adopting good oral self-care habits and seeking regular professional oral care.

In Costa Rica, the second edition of Lavatón was organised by the Colegio de Cirujanos Dentistas de Costa Rica, the local dental association. Dental professionals participating in this initiative visited more than 35 schools to educate students on toothbrushing, disease prevention and important oral hygiene habits. On 20 March, thousands of students across the country brushed their teeth simultaneously as part of Lavatón.

In Vietnam, over 6,000 people participated in the Run for Life WOHD 2015 race, which was sponsored by the Vietnam Odonto-Stomatological Association, Unilever and the Vietnamese Ministry of Health.

Unilever Kenya’s Closeup toothpaste brand and the Kenya Dental Association kicked off a new partnership in the town of Naivasha to support the WOHD “Smile for life” campaign with free dental check-ups and toothbrushing lessons that they will be rolling out across the country.

The “Smile for life” message was also broadcast to the world via the giant NASDAQ screen in Times Square in New York. A collage was shown of pictures that were individually created by users of a poster application specially introduced by the FDI for WOHD.

As the official media partner of WOHD 2015, Dental Tribune International provided comprehensive coverage of the FDI’s message. Among other activities, the publisher helped promote WOHD 2015 through news articles, banners and advertisements in its various international print publications and on its website, www.dental-tribune.com, including a topic page solely dedicated to WOHD 2015.
Shape and colour – factors in sectional matrices as well?

By Prof. Claus-Peter Ernst

Direct composite restorations can now be considered a proven treatment method in the posterior region [1, 3]. However, treatment can differ significantly with regard to extension and extent, and this can have a definite influence on long-term survivability. There are many factors that determine the long-term success of a composite restoration: tightly sealed edges are primarily guaranteed by the adhesive technique [2]. For dental materials, besides low shrinkage stress [4, 11], the material also has a high flexural strength [6, 10] in order to minimise the risk of the restoration undergoing a cohesive-type failure. A fractured filling is clearly a more dramatic event for the patient than a discoloured edge. For the patient, the success of direct posterior tooth treatment with composites thus depends on its stability. Besides the adhesive technique and the selection of materials for the restoration, the crucial key function of correct light polymerisation also plays a decisive role [5]. It is completely possible to double the flexural strength of one’s own composite just by using the correct light curing and light curing technique. A further possible influence on the stability of the composite restoration is less well-known: the correct anatomical shape of the interproximal surface. If this is shaped like a natural tooth, the interproximal contact is at the height of the tooth equator and the marginal ridge is not too eccentric. This reduces the risk of ridge fractures – both purely cohesive clipping fractures as well as more complex, mixed cohesive/adhesive failure patterns. Lusztyk et al. [8] were able to show that the stability of an interproximal composite restoration can be increased significantly by using an anatomically shaped matrix. The correct positioning of the interproximal contact also facilitates the achievement of sufficient contact strength – provided clamping rings are used correctly. Surprisingly, the interproximal contact strength is not the result of the pressure of a wooden wedge; it is primarily caused by the separation force of the sectional matrix [7, 9]. Autonomically – as a side effect – fewer interproximal food impactions occur as a result.

For this reason, sectional matrices are now the first choice when it comes to correctly designing interproximal composite surfaces. Circular matrices, even when they are anatomically shaped, should be used when it is not possible to fix sectional matrices in place. This is the case, for instance, for distal caviities on the last tooth in a row, as well as for teeth that are not anatomically positioned as for example a rotated tooth. The general acceptance of sectional matrix systems is also shown by the extensive range of sectional matrices and rings, which are now available. In general, sectional matrices can be roughly divided into two groups: dead-mat matrices and stable steel versions. The supporters of dead-mat sectional matrices like their easy mouldability and adaptability to the tooth. However, critics dislike their lack of sta-

Clinical case 1: Upper right 2nd premolar

The 48-year-old patient was treated six months ago with a Biocement (Septodont) filling to the 2nd upper right premolar (Fig. 1). The temporary filling is now to be replaced with what more safely used sectional matrix systems.

Clinical case 2: Lower right 1st molar with MIH, which needed a restorative treatment.

The 48-year-old patient exhibited molar hypomineralisation (MIH). His lower right 1st molar required restorative treatment. The excavation of the occlusal-buccal surface (Fig. 11). The 20-year-old patient exhibited molar-incisor hypomineralisation (MIH). His lower right 1st molar required restorative treatment. The excava-

Fig. 1: Lower right 1st molar with MIH, which needed a restorative treatment.

Clinical case 3: 1st lower right molar

The 20-year-old patient exhibited molar hypomineralisation (MIH). His lower right 1st molar required restorative treatment. The excavation of the occlusal-buccal surface (Fig. 11). For cost reasons, as well as from the viewpoint of minimally-invasive caries treatment, it was agreed with the patient to initially undertake direct treatment in the form of a resin composite restoration. Figure 12 shows the excavated, prepared cavity equipped with the LumiContrast separation ring. This offered the rare opportunity for a clinical-visual inspection of the interproximal surface of the 1st lower right molar created one year earlier.

Clinical case 3: Lower right 1st molar

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HEALTHIER & STRONGER TEETH*
STARTING FROM DAY 1
WITH CONTINUED USE

*ON ENAMEL PLAQUE AND ENAMEL EROSION VS ORDINARY TOOTHPASTE
While anxiously waiting for the “Downtown Abbey” television series to start up again, I got my English history I by reading the history of Wentworth Castle. The book covered the trials and tribulations of an aristocratic family in a home three times the size of Buckingham Palace. I was taken by surprise when the author mentioned the cause of death of a high-ranking nobleman as “quarney throat.”

In modern times, with the arrival of antibiotics, you wouldn’t hear of this — at least not in a developed nation. The more I thought about it, I don’t think I had heard the term “quarney sore throat” for a very long time. Although here, if your throat is starting to close off, you’re probably gotten yourself to an emergency room “pronto.” It is an “emergency” room, however, that is not the rival of antibiotics, you wouldn’t think about it, I don’t think.

George Washington’s physi- cian mentions his quinny sore throat prior to his death at age 63. He was thought to have suffered from a quinny sore throat that quickly turned into epiglottitis — most likely his cause of death. The swelling of his epi- glottis cut off his air supply. He also suffered from malaria, TB and smallpox during his lifetime. How sad that it may have been a very bad sore throat that got him in the end. The blood-letting technique that was used at the time probably hindered his recovery as well.

When I was a dental hygiene student, we were occasionally brought to a local city clinic to do checkups on grammar school children. These children were the poorest of the poor and were seen on old WW2 wooden field chairs. There was no money in the budget for fancy things like “discoloring Tablets.” Instead, we used iodine on long cotton swabs to paint the teeth and close the plaque, our instructor kept the large bottle of iodine. The iodine that a physician uses is water-based as opposed to the alcohol-based type available for home use. We used eye droppers to fill up a little glass glass, dappen dishes for each patient. I would think the taste alone would put children off dentistry for some time to come. We rinsed their mouths with a rub- ber ball syringe, and they expec- tered into a kidney basin. Consi- dering the number of patients I currently see with known iodine allergies, it’s amazing we never heard of any children having a reaction. The old-time iodine bottle with the skull and crossbones sits on my shelf, while others are simply shelves, while others are simply manufacturer’s known to combine potassium iodide with hydro- gen peroxide. Some businesses have removed iodine from the shelves, offering instead more strictly regulating large quantity sales — i.e., more than $100 worth. When I asked my local pharma-acist about Walgreen’s policy, he pointed to the surveillance cam- eras above the tincture of iodine shelf. Legitimate medical labora- tories that do gram staining have now additional paperwork due to the restrictions on iodine strengths and quantities.

Iodine getting harder to find

The old-time iodine bottle with the skull and crossbones sitting in the medicine cabinet has come and gone. In this new age of communication and entertainment, I wonder if a child would even be put off by the sight of a poison label. Children are exposed to cartoon pirates at such an early age. In the mid 19th century, cobalt blue bottles or raised glass lettering were used to help in the identification of poisons.

While there is no federal mandate for small quantities, iodine has disappeared from a few pharmacies and department store shelves. The way Sudafed did most recently. Home brew- ers take heart, these pharma- cists just require that you sign a poison-control statement and list the reason for your pur- chase. For those of you who still buy your beer in the traditional manner, iodine is often used as a flavoring agent for lager, or sturch conversion in the mash.

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Infection control in an era of emerging infectious diseases

By Eve Cuny, USA

The emergence of human immunodeficiency virus (HIV) as a global pandemic. More than any other infection, it is possible to single out HIV as the primary driver in changing infection control practices in dentistry. Prior to the mid-1980s, it was uncommon for dentists and allied professionals to wear gloves during routine dental procedures. Many dental clinicians did not use heat sterilisation, and disinfection of surfaces was limited to non-irritating, non-surgical alcohol soaked gauze sponge. This was despite our knowledge that HIV is very hardy and can be spread in clusters in the offices and clinics of infected dentists and that dentists were clearly at occupational risk for acquiring HBV. Today, many take safe dental care for granted, but there is still much vigilance in ensuring an infection-free environment for providers and patients. HIV has fortunately proven to be easily controlled in a clinical environment using the same precautions as those effective for preventing the transmission of HBV and hepatitis C virus.[1] These standard precautions include the use of personal protective attire, such as gloves, surgical masks, gowns and protective eyewear, in combination with surface cleaning and disinfection, instrument sterilisation, hand hygiene, immunisation and other basic infection control precautions.

Concern about emerging infectious diseases arises for several reasons. When faced with a particularly deadly infectious disease such as HIV, which can be spread through contact with an infected patient’s body fluids, health care workers are naturally concerned about how to protect themselves if an ill patient presents to the dental clinic. With diseases such as pandemic influenza and severe acute respiratory syndrome, which may be spread via inhalation of aerosolised respiratory fluids when a patient coughs or sneezes, the concern is whether standard precautions will be adequate. In addition to standard precautions, treating patients with these diseases requires the use of transmission-based precautions. These encompass what are referred to as contact, droplet and airborne precautions for diseases with specific routes of transmission. Transmission-based precautions may include patient isolation, placing a surgical mask on the patient when he or she is around other people, additional protective attire for care providers, and in some cases, the use of respirators and negative air pressure in a treatment room. In most cases, patients who are contagious for infectious requiring droplet or airborne precautions should not be treated in a traditional dental clinic setting.

The project emphasises the need for the use of fluoridated toothpaste administered by schoolteachers via an enhanced school health programme. (Photograph: Bork/Shutterstock)

Tackling poor oral health around the globe

By Dental Tribune International

COPENHAGEN, Denmark: Researchers from the University of Copenhagen have examined the benefits of enhanced oral health promotion combined with a closely supervised toothbrushing programme in schools in southern Thailand. The two-year study aimed to establish an effective model for the fight against the increasing burden of tooth decay among children in Asia.

The research project, which was based on the World Health Organization’s Health Promoting Schools concept, focused on increasing awareness of the importance of oral health in order to foster a healthy school environment and encourage regular dental care habits in young children. (Photograph: Stephane Bidouze/Shutterstock)

The research project in southern Thailand focused on increasing awareness of the importance of oral health in order to foster a healthy school environment and encourage regular dental care habits in young children. (Photograph: Stephane Bidouze/Shutterstock)

The research project emphasises the necessity of engaging the school as well as family and schoolteachers, said lead researcher Prof. Poul Erik Petersen, from the Department for Global Oral Health and Community Dentistry at the university’s School of Dentistry. “Globally, very few school health programmes are evaluated scientifically. This research project has provided sound information and will thus contribute to the promotion of preventive measures in school oral health programmes,” Petersen concluded.

According to Petersen, the experience gained from the study could offer new insight into the global fight against poor oral health in children. Further, he expressed the hope that the research results would assist ministries of health, public health administrators and oral health planners in low- and middle-income countries in Asia in developing evidence-based school health programmes.

In Asia, the number of children suffering pain and discomfort resulting from poor oral health, in addition to missing school lessons, is increasing. High levels of tooth decay in developing countries such as Thailand are primarily related to poor living conditions, the high intake of sugars, poor oral hygiene practices, low exposure to fluoride for disease prevention, as well as limited availability of and access to preventive dental health services.

The study, titled “School-based intervention for improving the oral health of children in southern Thailand”, was published in the March issue of the Community Dental Health journal.
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