Features, as well as the latest news providing editorials and special sections finalised in May, dental professionals are invited to learn about developments at EuroPerio, as well as other issues in the field. The event will also be a showcase for the most recent product innovations in oral health, which will be presented by up to 80 sponsors, including the UK’s own Dentaid, as well as major international dental consumables companies Johnson & Johnson, Oral-B and Sunstar.

Elected EFP President Prof. Phoebus Madianos from Greece stated, “A major priority for EFP is the general recognition of periodontology as a dental specialty in Europe. Therefore, the organisation is working with all relevant parties to promote the rationale of periodontology being recognised among regulators, licensing bodies and policymakers across Europe. Closely related to this goal of full recognition is the creation of a common curriculum for postgraduate studies in periodontology, promoted by the EFP according to standardised criteria, a project aimed at enabling free mobility of periodontal professionals and citizens across the EU, the ultimate aim being to improve the quality of treatment and people’s general health.”

Currently, the EFP represents 16,000 dental professionals, who belong to its 29 member associations, including the British Society of Periodontology located in Rumburgh in Yorkshire. Its last congress brought more than 7,000 visitors to Vienna in Austria in 2012.

For more information, news and updates please visit the event website at www.dental-tribune.co.uk.

DTI to publish official congress newspaper of EuPERIO

Publisher signs long-term agreement with European Federation of Periodontology

By DTI

LONDON, UK: Undoubtedly, the European Perio Congress today is among the leading conferences for periodontology and implant dentistry worldwide. Dental Tribune International (DTI) has recently signed an agreement with the event’s organiser, the European Federation of Periodontology, one of the largest dental associations in Europe, to establish DTI’s today show daily newspaper as the official congress guide of EuroPerio8.

As part of the agreement, DTI will publish three daily issues of today in English during the congress. The newspapers will be distributed to over 7,000 expected participants free of charge at the main entrances of the congress venue, the ExCel London Exhibition and Convention Centre.

In addition, the publisher will be providing editorials and special features, as well as the latest news from EuroPerio8 before, during and after the event, on its website, www.dental-tribune.com. Daily online coverage, including interviews with key opinion leaders and industry representatives, will be provided by an on-site editorial team. Moreover, users of the DTI website will have free access to a dedicated EuroPerio8 topic page, on which all important updates, photographs and videos will be published.

For more than a decade, DTI has partnered with some of the world’s largest exhibition and congress organisers, publishing more than 65 editions of its today show daily newspaper for major dental shows and events annually.

The publication allows for better planning and orientation, as well as provision of general business information for congress participants and exhibition visitors. It has also established itself as a platform for the dental industry for targeted communication.
The high prevalence of periodontal disease is alarming

An interview with EFP President Prof. Søren Jepsen, Germany, about EuroPerio8 in London

“We have been very creative and have done a really excellent job.

The issue of peri-implantitis is more relevant than ever with an increasing number of implants being placed worldwide. How is this important area reflected in the programme?

Several main sessions are dedicated to this area and there will be a number of internationally renowned experts, including EFP General Secretary Prof. Stefan Renvert and EFP-treasurer Jörg Meyle, who will speak about this issue. Moreover, some of the scientific short presentations will deal with peri-implant disease from a patient’s perspective. This will be followed by a podium discussion involving patients and clinical experts.

Despite a high prevalence, periodontal disease still does not attract the attention it deserves, even in developed countries. Where do you see the main obstacles and what can be done to raise awareness among professionals and the general public?

The same message is carried by the manifesto and we invite everyone to support this mission by signing it at www.efp.org/efp-manifesto.

Next year, the EFP will be celebrating its 25th anniversary. How do you see the role of the organisation within dentistry, and what goals are on the agenda for the time being?

We will certainly celebrate this anniversary properly at the general assembly of all national member societies of the EFP next year in Berlin. However, the party starts already here in London, where our colleagues and friends from all over the world are assembled.

At this point, the EFPs already one of the worldwide driving forces in the field of periodontics and implant dentistry. Its influence on dentistry, particularly through its annual conference (European workshop) and EuroPerio, should not be underestimated. We also have to acknowledge the EFPI’s journal of Clinical Periodontology with its editor Prof. Maurizio Tonetti.

For the next three years, we are planning to advance our vision of “Periodontal health for a better life”. For this, we will communicate the most important findings from our consensus conferences with regard to the interrelationship between oral and general health, as well as the prevention of periodontal and peri-implant disease, to the public. As mentioned, we are currently in preparations to launch a European-wide campaign.

Thank you very much for the interview.

Dental Tribune United Kingdom Edition | 2/2015
LONDON’S TOP 10 ATTRACTIONS

1. BRITISH MUSEUM
The world-famous British Museum exhibits the works of man from prehistoric to modern times, from around the world. Highlights include the Rosetta Stone, the Parthenon sculptures and the mummies in the Ancient Egypt collection. Entry is free but special exhibitions require tickets.

2. NATIONAL GALLERY
The crowning glory of Trafalgar Square, London’s National Gallery is a vast space filled with Western European paintings from the 13th to the 19th centuries. In this iconic art gallery you can find works by masters such as Van Gogh, da Vinci, Botticelli, Constable, Renoir, Titian and Stubbs. Entry is free but special exhibitions require tickets.

3. NATURAL HISTORY MUSEUM
As well as the permanent (and permanently fascinating!) dinosaur exhibition, the Natural History Museum boasts a collection of the biggest, tallest and rarest animals in the world. See a life-sized blue whale, a 40-million-year-old spider, and the beautiful Central Hall. Entry is free but special exhibitions require tickets.

4. TATE MODERN
Sitting grandly on the banks of the Thames is Tate Modern, Britain’s national museum of modern and contemporary art. Its unique shape is due to it previously being a power station. The gallery's restaurants offer fabulous views across the city. Entry is free but special exhibitions require tickets.

5. THE LONDON EYE
The London Eye is a major feature of London’s skyline. It boasts some of London’s best views from its 32 capsules, each weighing 10 tonnes and holding up to 25 people. Climb aboard for a breathtaking experience, with an unforgettable perspective of more than 55 of London’s most famous landmarks – all in just 30 minutes!

6. SCIENCE MUSEUM
From the future of space travel to asking that difficult question: “who am I?”, the Science Museum makes your brain perform Olympic-standard mental gymnastics. See, touch and experience the major scientific advances of the last 300 years; and don’t forget the awesome Imax cinema. Entry is free but some exhibitions require tickets.

7. VICTORIA & ALBERT MUSEUM
The V&A celebrates art and design with 3,000 years’ worth of amazing artefacts from around the world. A real treasure trove of goodies, you never know what you’ll discover next: furniture, paintings, sculpture, metal work and textiles; the list goes on and on... Entry is free but special exhibitions require you to purchase tickets.

8. TOWER OF LONDON
Take a tour with one of the Yeoman Warders around the Tower of London, one of the world’s most famous buildings. Discover its 900-year history as a royal palace, prison and place of execution, arsenal, jewel house and zoo! Gaze up at the White Tower, tip toe through a medieval king’s bedchamber and marvel at the Crown Jewels.

9. ROYAL MUSEUMS GREENWICH
Visit the National Maritime Museum - the world’s largest maritime museum, see the historic Queen’s House, stand astride the Prime Meridian at Royal Observatory Greenwich and explore the famous Cutty Sark: all part of the Royal Museums Greenwich. Some are free to enter; some charges apply.

10. MADAME TUSSAUDS
At Madame Tussauds, you’ll come face-to-face with some of the world’s most famous faces. From Shakespeare to Lady Gaga you’ll meet influential figures from showbiz, sport, politics and even royalty. Strike a pose with Usain Bolt, get close to One Direction or receive a once-in-a-lifetime audience with Her Majesty the Queen.

VISITLONDON.COM
Where periodontology has advanced

By Prof. Mark Bartold, Australia

Over the past 20 years there have been some exceptional advances made in periodontology. Many of these have led to changes in our thinking and our approach to periodontal therapy. In 1999, the American Academy of Periodontology (AAP) devised a “new” classification system for the periodontal diseases. From this some 50 different types of periodontal conditions were identified which were considered worthy of individual classification. Clearly this was an unwieldy system and in reality it was distilled down to three main types of plaque-associated periodontal diseases: gingivitis, chronic periodontitis and aggressive periodontitis.

While the appropriateness of the terms “chronic” and “aggressive” have been debated they have served as a framework for both clinicians and researchers to define specific types of periodontitis with identifiable clinical parameters. It also provided a framework for understanding management protocols and outcomes. Nonetheless, over time it has become evident that such a classification system (chronic and aggressive) may be too simplistic because of the heterogeneity of the periodontal disease. Therefore, it may be timely to revisit such a classification system and determine whether current understanding of the epidemiology and pathology of these diseases can be used to better define them.

However, it is worth noting that in the past 25 years there have been at least 10 different classification systems proposed, none of which have been fully adopted. Clearly there remain a number of important challenges in this field. Since chronic and aggressive periodontitis are heterogeneous groups of diseases, for example, there will be unique subcategories based on their multifactorial nature and microbial, host response and environmental components. At present, apart from “plaque-associated” designation, the current AAP classification is not based on cause-related criteria.

Recognition that bacteria are necessary but not sufficient for periodontitis to develop

During the 1990’s a very important conceptual advance occurred in our understanding of dental plaque. As plaque is an integral part of the subgingival environment. The recognition that subgingival plaque existed as a biofilm with its own extracellular matrix and communicative properties changed our thinking of how the subgingival microbiota interacted not only with itself but also the host. Notwithstanding, this research through the filling holes in bone, rather than studying the natural healing processes required to regenerate the periodontal attachment apparatus. Ignorance of the contribution of the various tissue components in periodontal wound healing explained the widespread misuse of bone transplantation in the treatment of initial pocket disease which unfortunately still pervades some areas of periodontology.

It is now recognised that regenerative treatment of periodontal defects with an agent or procedure, requires that each functional stage of reconstruction be grounded in a biologically directed process. With such concepts in mind, the seminal studies of Karring, Nyman and coworkers from Gothenburg in Sweden led to the development of guided tissue regeneration (GTR) as a treatment modality. While this was a significant advance it became evident that while periodontal regeneration was biologically possible, it was clinically very difficult to achieve on a reliable basis owing to a vast range of patient and operator variables.

More recently we have seen the development of biological agents and preparations which, when applied onto root surfaces, can result in significant regeneration of damaged periodontal tissues. The use of such agents offers a simpler approach to periodontal regeneration with equivalent, and sometimes superior, results compared to GTR procedures. However, as has been noted for GTR, the clinical outcomes using biological agents can be variable and further work is needed to improve their clinical utility. Moreover, the use of mesenchymal stem cells and genetic modulation of periodontal cells have been explored for the purposes of achieving periodontal regeneration. The future looks promising but no doubt there is a considerable amount of work to be done before reliable and predictable periodontal regeneration becomes a reality.

TRENDS & APPLICATIONS

Regeneration of damaged periodontal tissues as a result of periodontitis has been considered the ultimate goal of periodontal treatment. Over the decades many procedures have been advocated, mostly associated with root surface conditioning and implantation of bone substitutes into periodontal defects as a means of obtaining periodontal regeneration. Unfortunately, these early concepts were naive owing to a poor understanding of the requirements for periodontal regeneration, namely the encouragement of new cementum, bone and periodontal ligament. Filling a periodontal defect with a substance which had no relevance to the next functional stage of reconstruction is irrational. Nonetheless, as a profession, we had become obsessed with filling holes in bone rather than studying the natural healing processes required to regenerate the periodontal attachment apparatus. Ignorance of the contribution of the various tissue components in periodontal wound healing explained the widespread misuse of bone transplantation in the treatment of initial pocket disease which unfortunately still pervades some areas of periodontology.

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At EuroPerio in Vienna, Prof. Barfied will be presenting a paper on periodontal medicine as part of the scientific programme in Capital Suite 2-4.

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Archimedes of Syracuse (c. 287 BC – c. 212 BC)

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The TwinLight® approach to peri-implantitis

By Dr Hay Maden & Dr Zafer Kazak, UK

As the number of dental implants being placed increases, reported cases of peri-implantitis are becoming more frequent. The available data suggest that one in five implant patients will develop peri-implantitis, an irreversible inflammatory condition characterised by bone loss around the site of an implant, while four in five will exhibit peri-implant mucositis, an early stage of the disease in which the inflammatory reaction is still reversible.1

With peri-implant mucositis, the inflammation is limited to the peri-implant mucosa, while with peri-implantitis the infection also spreads to the peri-implant bone. Both conditions include the presence of bacterial plaque and calculus, oedema and redness of tissues, and involve bleeding on probing. In the majority of cases, the inflammation is still reversible.2

The most prevalent reason for the development of peri-implantitis appears to be poor occlusal load distribution, with either primary contacts or cantilever bridges in implant-supported prostheses. Good oral hygiene on the patient’s part is mandatory; however, the position and design of prostheses that are difficult to manage may limit the effectiveness of mechanical cleaning. Once the underlying reason has been determined and recurrence is prevented, laser therapy can help to treat peri-implantitis.

The TwinLight® peri-implantitis treatment

A new laser treatment called TwinLight® from Fotona is proving to be one of the most effective methods for fighting peri-implantitis, successfully meeting the objectives of controlling infection by surface decontamination and halting the disease’s progression. TwinLight® is a minimally invasive technique combining dentistry’s two gold-standard laser wavelengths (Er:YAG and Nd:YAG) in a synergistic process designed to improve peri-implantitis treatment success rates and shorten healing time.

With TwinLight®, the Er:YAG laser is used in a non-surgical procedure to remove microbial contamination and halting the inflammatory reaction. The same laser is used in a surgical procedure to remove the damaged alveolar bone around the implant. Using Er:YAG, it is possible to clean the granulation tissues, both on the bone and implant surfaces, and thoroughly decontaminate the site. Removal of granulation tissue from the alveolar bone and connective tissue with Er:YAG is highly effective. The erbium laser targets the water content to remove the granulation tissue selectively, due to its long pulse duration and lower peak power, while abating the microorganisms on the surface of the bone.

The bactericidal effect of Er:YAG on the surgical site is effective against lipopolysaccharides, and the implant surface is completely cleaned without chemicals. The subsequent Nd:YAG treatment step promotes faster healing by bacterial reduction and biostimulation of the bone tissue. The same principles apply also with more severe treatments that require surgical therapy.

The TwinLight® procedure

The TwinLight® procedure is performed according to the following five steps:

- Step 1: Removal of the soft-granulation tissue with Er:YAG in LP mode (Fig. 1).
- Step 2: Removal of the bacterial biofilm on the implant surface with Er:YAG in VLP mode (Fig. 2).
- Step 3: Ablation of the infected bone with Er:YAG in QSP mode (Fig. 3).
- Step 4: Bacterial reduction in the bone tissue with Nd:YAG in MSP mode (Fig. 4).
- Step 5: Biostimulation with Nd:YAG in VLP mode (Fig. 5).

For treatment of peri-implant mucositis, only step 2 is performed.

Because the Er:YAG wavelength is used with an optimal modality, there is no danger of thermal damage to the highly fragile surrounding bone and no significant alterations of the implant surface, as is frequently the case with other lasers.3 The effect of the laser energy on the implant surface is dependent on the amount of energy density, power and pulse duration. The parameters should be chosen cautiously—lowering the settings may make the procedure slower but safer for reosseointegration. Non-surgical use of Er:YAG is also possible if the problem is not extensive.

Clinical Case

In the accompanying clinical case, a removable prosthetic with two ball attachments was planned. Due to the patient’s request, the implants were immediately loaded, which most probably is the reason for the resorption.

Fig. 1: Removal of the soft-granulation tissue with Er:YAG in LP mode. – Fig. 2: Removal of the bacterial biofilm on the implant surfaces with Er:YAG in VLP mode. – Fig. 3: Ablation of the infected bone with Er:YAG in QSP mode. – Fig. 4: Bacterial reduction in the bone tissue with Nd:YAG in MSP mode. – Fig. 5: Biostimulation with Nd:YAG in VLP mode. – Fig. 6: Pre-op X-ray - Fig. 7: Pre-op X-ray zoomed. – Fig. 8: Pre-op clinical.

Fig. 6a: De-granulation and disinfection of the implant surface with Er:YAG laser. – Fig. 6b: Bacterial reduction and biostimulation of the bone with Nd:YAG laser. – Fig. 7a: 3 years post-op X-ray. – Fig. 7b: 3 years post-op X-ray zoomed.
seen around the implant on the right lower jaw (Fig. 5). The site was directly accessed to clean the granulation tissue and disinfect the implant surface with Er:YAG laser, while bacterial reduction and biostimulation were executed with Nd:YAG laser (Fig. 6). The defect was augmented with synthetic bone substitute.

After three years of follow up with very good healing (Fig. 7), the patient demanded a fixed prosthetic, which was delivered with an additional placement of implants in both jaws. X-rays taken 5 years after the peri-implantitis treatment can be seen in Fig. 8. Two more implants were placed distally when the patient could afford more treatments after one year.

There are a number of advantages of using lasers in this type of case. One of them is that there is no mechanical, chemical or any other means of trauma while removing the granulation tissue around the implant—neither to the implant nor to the bone tissue. In addition to being safe, both wavelengths are known to promote healing by bacterial reduction and biostimulation of the tissue. Shorter pulses are used on the surface of the implant to avoid thermal effects, but with lower energies, so as to not have a too high peak power and thereby damage the surface. With short pulses and higher peak power (higher energy), we can create bleeding spots on the bone to improve healing of the augmentation material.

The penetration of Nd:YAG through bone helps the achievement of bacterial reduction and biostimulation. Care should be taken to avoid contacting the implant surface with Nd:YAG because the absorption in titanium is high and could cause a rise in temperature. It is also important to use a fast, sweeping motion with high suction to avoid heat accumulation on one spot. Too much bleeding would block the penetration of the Nd:YAG laser. Nd:YAG can also be used on the incision line, vestibular, the oral side of the surgical site and extraorally after suturing, and every second day for faster and better healing, with less pain and swelling.

Editorial note: A list of references is available from the publisher.

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Dr Ilay Maden is the co-director of Seesaw Dental Education Independent Dental Laser Courses, a UK-based affiliate of the Aachen Dental Laser Center in Germany. He can be contacted at ilaymaden@gmail.com.
The glass hybrid revolution

EQUIA Forte
from GC

EQUIA Forte takes the proven EQUIA approach to the next level. No need for conditioning or bonding with its built-in universal adhesive technology and outstanding wettability. EQUIA Forte is extremely tolerant and bonds equally well to all surfaces even in the deepest of lesions. With EQUIA Forte Coat acting like a lustre coating, you save on polishing time and achieve excellent aesthetics in no time.