A new mobile diagnostic platform is designed to speed up identification of the eleven most relevant periodontitis pathogens considerably. Scientists at the Fraunhofer Institute for Cell Therapy and Immunology IZI in Leipzig have collaborated with two companies, BECIT GmbH and ERT-Optik, to develop a lab-on-a-chip module called ParoChip. In future this will allow dentists and medical labs to prepare samples quickly and then analyze the bacteria. All the steps in the process - the duplication of DNA sequences and their detection - take place directly on the platform, which consists of a disk-shaped microfluidic card that is around six centimetres in diameter. “Until now, analysis took around four to six hours. With ParoChip it takes less than 30 minutes. This means it’s possible to analyse a large number of samples in a short amount of time,” says Dr. Dirk Kuhlmeier, a scientist at the IZI.

Samples are taken using sterile, toothpick-shaped paper points, after which the bacteria are removed from the point and their isolated DNA injected into reaction chambers containing dried reagents. There are eleven such chambers on each card, each featuring the reagent for one of the eleven periodontal pathogens. The total number of bacteria is determined in an additional chamber, via polymerase chain reaction (PCR). This method allows millions of copies of even tiny numbers of pathogen DNA sequences to be made.

In order to generate the extremely quick changes in temperature that are required for PCR, the disk-shaped plastic chip is attached to a metal heating block with three temperature zones and mechanically turned so it passes over these zones. This causes a fluorescent signal to be generated that is measured by a connected optical measuring device featuring a fluorescence probe, a photo detector and a laser diode.

The signal makes it possible not only to quantify each type of bacterium and thus determine the severity of the inflammation, but also to establish the total number of all the bacteria combined.

According to an article published in the January/February 2013 issue of General Dentistry, the peer-reviewed clinical journal of the Academy of General Dentistry (AGD), obesity may be a risk factor for gum disease.

“We know that being overweight can affect many aspects of a person’s health,” says Charlene Krejci, DDS, MSD, lead author of the article. “Now researchers suspect a link exists between obesity and gum disease. Obese individuals’ bodies relentlessly produce cytokines, proteins with inflammatory properties. These cytokines may directly injure the gum tissues or reduce blood flow to the gum tissues, thus promoting the development of gum disease.”

Research on the relationship between obesity and gum disease is still on-going.

“What we do know is that it’s important to visit a dentist at least twice a year so he or she can evaluate your risks for developing gum disease and offer preventive strategies.” The best way to minimise the risk of developing gum disease is to remove plaque through daily brushing, flossing, rinsing, and professional cleanings.

“A dentist can design a personalised program of home oral care to meet each patient’s specific needs,” says Dr. Shamoon.
Blackberries could prevent and treat gum disease

A new research report published in The Journal of Periodontal Research, the antibacterial properties of blackberry extract could help to prevent or aid in the treatment of gum disease, which, if left untreated, may result in tooth loss.

Natural extract from blackberries have previously been linked with blocking the spread of cancer cells, and showed the greatest total antioxidant capacity when measured against blueberry, raspberry, red currant, and both cultivated and wild strawberries.

Blackberries join a growing list of foods that could help prevent oral health problems. Strawberries and green vegetables have been linked to reducing the chance of developing oral cancer, not to mention potential heart problems too.

“Gum diseases and the infections that cause them can be incredibly stubborn and difficult to treat,” said John Wherry, Ph.D., Deputy Editor of the Journal of Leukocyte Biology. “What isn’t as well known is why these infections are so difficult to eradicate. These new studies now demonstrate that these bacteria go beyond merely evading our body’s defenses and actually manipulate our immune system. They keys becoming infected with the monkey AIDS virus. This was based on epidemiological evidence that shows that infection and immunodeficiency of the mucosa increases the chances of becoming infected with HIV by the sexual route.”

Gingivitis bacteria manipulates immune system

A new research report published in the Journal of Virology shows how the bacteria known for causing gum disease, Porphyromonas gingivalis, manipulates the body’s immune system to disable normal processes that would otherwise destroy it.

Specifically, the report shows that this pathogen prompts the production of the anti-inflammatory molecule Interleukin-10 (IL-10). This, in turn, inhibits the function of T-cells, which would otherwise help to protect the host from this particular microbial infection.

To make this discovery, scientists used cells from mice that were exposed to P. gingivalis. One portion of the cells was treated with an inhibiting antibody against IL-10 and the other portion of cells was not treated. All of the cells were then tested for interferon gamma production. An increase of interferon gamma production was seen in the treated cells, but no increase was found in the untreated cells.

These findings suggest that the damage done by P. gingivalis happens when the immune cells of the host are first exposed to this pathogen, and further implies that for treatment to be successful, it must be started as early as possible.

This study highlights the mechanism by which P. gingivalis can establish a chronic infection in the form of periodontal disease and provides insight into how the disease develops.

Results also demonstrate the importance of very early intervention either by eradication of the bacterium or specifically designed therapeutics or by prevention via the development of an effective vaccine.

Gum disease may worsen AIDS

S cientists at the Texas Biomedical Research Institute have found that moderate gum disease in an animal model exposed to an AIDS-like virus had more viral variants causing infection and greater inflammation. Both of these features have potential negative implications in long-term disease progression, including other kinds of infections, says the report published in the Journal of Virology.

The public health message from the study is that even mild inflammation in the mouth needs to be controlled because it can lead to more serious consequences, said Luis Giavedoni, first author of the study.

“After infection with the simian AIDS virus, the generalised acute inflammation induced by the virus was exacerbated in the animals with gingivitis, indicating that even mild localised inflammation can lead to a more severe systemic inflammation,” he said.

Giavedoni and his colleagues studied whether inflammation of the mouth would increase the susceptibility of the monkeys becoming infected with the monkey AIDS virus. This was based on epidemiological evidence that shows that infection and immunodeficiency of the mucosa increases the chances of becoming infected with HIV by the sexual route.

The scientists induced moderate gum inflammation in a group of monkeys, while a second group without gum inflammation served as a control. After exposing both groups of macaques to infectious SIV, a monkey virus similar to AIDS, they did not observe differences in the rate of infection in the mouth, indicating that moderate gum disease did not increase the chances of getting infected with the AIDS virus.

“However, we did observe that the animals that had gum inflammation and got infected had more viral variants causing infection and they also showed augmented systemic inflammation after infection; both of these findings may negatively affect the progression of the viral infection,” Giavedoni said.

Study links periodontitis with diabetes

Long-term data published in Diabetes Research and Clinical Practice has provided further scientific evidence that people with Type 2 diabetes mellitus (T2DM) have a great risk of periodontitis.

The researchers have sent over 50,000 males biennial questionnaires, since, 1988, and from their data found that “at baseline, men with T2DM were more likely to report hypertension, were missing more teeth, consumed less alcohol, and were less likely to be dentists than those without.”

Risk of periodontitis was found to be 59 per cent higher in men with T2DM than in men without, T2DM was also associated with a 22 per cent increased risk of tooth loss compared with those without.

“In this study with 20 years follow-up, T2DM was significantly associated with greater risk of self-reported periodontitis”, the study authors wrote.

“These results hold important public health implications due to the associations between periodontitis and cardiovascular disease and nutritional alterations associated with tooth loss. Greater collaboration between dentists and endocrinologists could be used to identify at-risk patients in both clinical settings.”
EuroPerio7 - A Sparkling Success!
Report by Peter Galgut

EuroPerio is a tri-annual conference in which everyone involved in periodontics in Europe and farther afield gathers together to learn and see what's new and what is up and coming in periodontics. This year the 7th conference was held in the beautiful old city of Vienna, with all its lovely restaurants and coffee houses, beautiful buildings, galleries, palaces and lovely congenial atmosphere.

Dentists, hygienists, periodontists in clinical practice, teachers, professors, and research workers in periodontics gather together to share their knowledge and experience and learn from each other. The social programme brings people together in a formal way so that old friends can catch up with each other and renew old friendships. However most of the socialising goes on in the many cafes and corridors in and around the conference centre.

The programme is so extensive that many lectures go on concurrently and it is often difficult to choose which one to go to as there is always something of interest to the clinician as well as researchers’ students, hygienists and general dental practitioners.

EuroPerio is a tri-annual conference in which everyone involved in periodontics in Europe and farther afield gathers together to learn and see what’s new and what is up and coming in periodontics.

The Secret to Dental Lab Survival in the Next Decade?

Go Digital.

For a dental lab to survive in today’s market you need to expand your reach. Win new customers. Open fresh markets.
In short – you need to go digital!
3D printing helps you better plan and execute your digital dental workflow so your clients will immediately notice the difference in quality and turnaround.
Objet 3D Printers from Stratasys are leading the digital dental revolution and can be found in many of the world’s leading dental labs, including Glidewell, Albensi, ClearCorrect and ClearStep. So why let it wait?
Contact Stratasys to find out why now is the right time to move to digital dental production with Objet 3D Printers.

Come see us at:
IDS / 12 – 16 March 2013 / Cologne, Germany / Hall 3.2 Stand F020/G021

Find out how Objet 3D Printing from Stratasys can transform your dental business today.
stratasysdental.com • dental@stratasys.com
The trade show usually has over 100 participants showcasing the newest and the best products in preventive and periodontal care available in Europe with some companies also from the United States and elsewhere.

The 2012 conference featured lectures on implantology, highlighting new implants, and new techniques for not only placing implants, but maintaining them as well. Several companies had innovative systems for sinus lift procedures and placing graft material into the sinus cavity utilizing minimal surgical intervention techniques.

Other lectures covered new concepts in periodontal disease management, preventive care. So, this is not just a conference for periodontists but there is something for everyone who is interested in preventive and periodontal care.

What is really exciting is that the next EuroPerio (8) conference is going to be held right here in London. The organising committee of the British Society of Perio is working hard at putting this major international conference together, and it is a great opportunity to showcase the best in British dentistry to Europe. The conference is scheduled to take place in the Excel Centre on 3-6 June 2015, so please put the date in your diary, and register for the conference as soon as the bookings open.
Perio-endo lesion: Dilemma unfolded
Dr Naylah Fajandar, MOs, Dr. Sneha R. Gokhale-Gaikwad, MDS, Dr. Sameer Jadhav, MDS, Dr. Vivek Hegde, MDS

Scientific advances have fragmented the field of dentistry into a vast number of specialisations. Each specialised clinician performs a specific task. However, there are instances where treatment from single specialist will not eradicate the disease, the reason being the intricate nature of tooth, with its surrounding environment. In such cases it then becomes mandatory to adopt an interdisciplinary approach among professionals for complete rehabilitation. An interdisciplinary approach is most commonly required in cases of an Endodontic-Periodontic lesion.

The relationship between periodontal and pulpal disease was first described by Sieving and Goldberg in 1964. Since then the term ‘Perio-Endo’ lesion has been used to describe these lesions. Perio-endo lesions arise from inflammation or degeneration of both pulpal and periodontal tissues as a result of an intimate embryonic, anatomic and functional inter-relationship between them.

The various pathways of communication between the pulp and the periodontium may be classified as follows:

I) Developmental pathways include the apical foramen, lateral or accessory canals, dentinal tubules, developmental or lingual grooves

II) Pathological pathways include empty spaces created by destroyed sharpay’s fibers, root fractures following trauma, idiopathic resorption (internal or external) and cemental agenesis or hypoplasia.

III) Iatrogenic pathways include exposure of dentinal tubules following root planning and accidental lateral perforations during endodontic treatment.

Endodontic-periodontic diseases can be classified into:

A. Primary endodontic disease: A chronic apical abscess may drain coronally through the periodontal ligament into the gingival sulcus. This condition may mimic clinically the presence of a periodontal abscess. Primary endodontic lesions usually heal following root canal treatment.

B. Primary periodontal disease: These lesions are caused primarily by periodontal pathogens. In this process, chronic periodontitis progresses apically along the root surface. In most cases, pulp tests indicate a clinically normal pulp reaction.

C. Combined lesions: Primary endodontic disease with secondary periodontal involvement:

If after a period of time a suppurating primary endodontic disease remains untreated, it may become secondarily involved with periodontal breakdown. The tooth now requires both endodontic and periodontal treatments. If the endodontic treatment is adequate, the prognosis depends on the severity of the periodontitis and the efficacy of periodontal treatment. With endodontic treatment alone, only part of the lesion will heal to the level of the secondary periodontal lesion.

Primary periodontal disease with secondary endodontic involvement:

The apical progression of a periodontal pocket may continue until the apical tissues are involved. In this case the pulp may become necrotic as a result of infection entering via lateral canals or the apical foramen.

True combined disease:
True combined endodontic-periodontal disease occurs less frequently than other endodontic-periodontal problems. It is formed when an endodontic disease progressing coronally joins with an infected periodontal pocket progressing apically. In most cases periapical healing may be anticipated following successful endodontic treatment.

This case report describes a case with most common symptoms of pain and swelling.

Case Report:
A 35-year-old male patient reported to the Department of Periodontics, M.A. Rangoonwala Dental College and Research Center, Pune with the complaint of pain, swelling and pus discharge from the mandibular right posterior region for four to five days. The tooth pain was moderately throbbing in nature and aggravated on mastication. The patient first noticed a small swelling in the gingiva which increased in size over three to four days. The dental and history was non-contributory.

On clinical examination the patient presented a small swelling in relation to mandibular right first molar. No caries or restoration was present. There was no evidence of vertical or horizontal...
fracture. The gingiva in relation to the involved tooth appeared soft and oedematous whereas the generalised consistency of the gingiva appeared normal and resilient (Fig 1). Bleeding on probing was also present in the same area. Periodontal probing depths were materially 10mm, distally 5mm, buccally 6mm and lingually 5mm. The tooth showed grade I mobility and grade II furcation involvement. The patient experienced pain on vertical percussion. A periapical radiograph showed widening of the periodontal ligament space, radicular cyst in furcation area and differential bone loss along the mesial root (Fig 2). Electric pulp vitality test resulted in response, thus indicating a vital pulp. A periodontal abscess associated with mandibular right first molar was diagnosed. The lesion was diagnosed to be of primary periodontal origin with secondary endodontic involvement.

Emergency Treatment:
The abscess was drained through the pocket and a thorough irrigation with Betadine was performed. Antibiotics were not prescribed as the patient was afebrile and there was no evidence of regional lymphadenopathy.

Phase I therapy: The patient was recalled for scaling and root planning after four days. Patient continued to complain of mild pain though the swelling had reduced. After evaluation of the Phase I therapy, endodontic therapy was initiated.

Definitive treatment: An access cavity was prepared and the root canal system was cleaned and shaped during the first session using Protaper (Dentsply) along with copious irrigation with 5.25 per cent sodium hypochlorite and saline. The patient returned after one week and the endodontic treatment was completed using six per cent guta percha and AH Plus sealer (Dentsply Maillefer). Post endodontic restoration was done with silver amalgam. (Fig 3)

After the endodontic treatment, the patient was asymptomatic and the gingiva appeared healthy. However, the pocket probing depths were still nine and 5mm mesially and buccally respectively. Access flap surgery was performed to eliminate the pocket. After flap reflection, debridement of the defect and furcation was performed using hand cutters (Hu Freidyl®) and ultrasonic instrumentation (Figure 4). The intrabony defect was a combination of two and three wall defect. Two wall defect in the coronal portion of the mesial root and three wall defect apically (Fig 5). Freezedried bone allograft (FDBA) was placed in the furcation as well as in the intrabony defect (Fig 6). The flaps were approximated with the help of 5.0 black braided silk suture (Sterisil®). The graft material was completely covered and the flap was closely adapted to the tooth. Periodontal dressing was placed. Amoxicillin 500mg tid was prescribed for five days to assure minimal infection during healing phase. Immediate post operative radiograph was taken which shows evidence of graft material in the defect and the furcation area (Fig 7). Patient was recalled after a week for removal of sutures.

Patient was recalled at regular intervals for maintenance program and oral hygiene instructions were reinforced. There was no evidence of antigenic response to the graft. Radiographs were taken at the intervals of six months and one year. The radiographic picture clearly shows bone fill in the furcation and intrabony defect after one year (Fig 8). Thus the tooth was successfully treated by endodontic and periodontal interventions with satisfactory results.

Discussion:
In periodontitis, a periodontal abscess represents a period of active bone destruction (exacerbation), although such events also occur without abscess formation. The existence of tortuous pocket may favour the formation of abscesses (Carranza 1990). The marginal closure of the periodontal pocket, may lead to an extension of the infection into the surrounding periodontal tissues due to the pressure of the suppuration inside the closed pocket (Kareha et al 1981, Newman and Sims 1979). Changes in the composition of the microflora, bacterial virulence, or in host defences could also make the pocket lumen inefficient to drain the increased suppuration.

In this case, periodontal abscess was a result of Chronic Periodontitis with secondary endodontic involvement. It has been suggested that intrapulpal infection tends to promote marginal epithelial down growth along a denuded dentin surface (Blomlof et al. 1992). Additionaly, experimentally induced periodontal defects in infected teeth were associated with 20 per cent more epithelial down growth than non-infected teeth. Non-in- fected teeth showed 10 per cent more connective tissue coverage than infected teeth (Janson et al 1995). Hence, the endodontic therapy was performed before a definitive periodontal therapy.

Periodontal surgical procedures result in a harmonious anatomical relationship between the tooth and gingiva as well as correction of any underlying osseous defects which leads to positive correlation between the contour of the gingiva and the topography of the underlying alveolar bone. Persisting osseous irregularities may result in residual deep sulci or pockets making a sustainable level of acceptable plaque control more difficult, thus increasing the chances of further periodontal breakdown.

Periodontitis is a chronic immune-inflammatory disease caused due to infection by specific micro-organisms. A chronic lesion consists of macrophages, plasma cells, granulation tissue and destructed collagen fibres. An acute inflammatory response results in dynamic healing response to appropriate therapy.
and is more favourable for achieving new attachment.

Therefore periodontal flap surgery along with bone graft placement and grafting is a more predictable flap raisable response in this case. Trombelli et al. (2002), in his systematic review stated that use of biomaterials along with open flap debridement was more effective in improving attachment levels in intra-osseous defects. The morphology of the defect is an important factor that determines the outcome of the regenerative therapy. In this case, there was a combined two to three wall defect and a grade II furcation involvement which provides most predictive outcome of grafting procedures. The management of grade II furcation involvement presents a unique clinical problem. Reasons for compromised results in furcation areas include the lack of proper access for instrumentation as well as for proper maintenance care due to the complex furcation anatomy and consequently a persistence of pathogenic microflora.

The recent systematic review by Scalean et al. (2008) provides histological evidence of periodontal regeneration with the use of grafts and barrier membranes in combination. However, the combination of grafts and barrier membrane did not provide additional advantage in Grade II furcation and three wall defects. The space providing properties of the graft material proved to be useful in periodontal regeneration. In this case, barrier membrane was not used as the tissues were fragile and there was a risk of membrane exposure. However, satisfactory results have been obtained with FDBA as a bone graft material.

Mineralised freeze dried bone allograft (FDBA) has osteoconductive properties thus acts as a scaffold for bone formation. Extensive research has been done on FDBA as a graft material. Mellonig in 1991 found that at least 50 per cent bone fill in 67 per cent of periodontal defects and the percentage increased to 78 per cent if it was combined with autograft.

In the present case, the lesion was primarily of periodontal origin with secondary endodontic involvement. Therefore, the success of the treatment depended on the periodontal treatment. Satisfactory results were obtained after access flap surgery along with the use of FDBA.

Conclusion: The endo-perio lesions have always been a diagnostic and prognostic dilemma. The treatment plan also varies depending upon the type of lesion. Primary endodontic and periodontal lesions heal completely by endodontic and periodontal therapy respectively. However, combined lesion often requires both endodontic and periodontal therapy. Proper diagnosis, decision making and treatment plan can change the prognosis of such cases from hopeless to hopeful.

References:
Oral health in old age: Mouthwash as an adjunct for the elderly

Howard Thomas discusses the importance of oral hygiene in the elderly

According to Government statistics, there are 10 million people in the UK who are over 65 years old and this figure is anticipated to almost double by 2050. Added to this, life expectancy continues to increase; a baby born nowadays might expect to live to 91 or 92 years of age. However, healthy life expectancy is not keeping up with our ageing population, the Government claims, because of older residents’ proportionally greater demands on public services.

These demographic trends highlight the need for dental professionals to focus their attention on the maintenance or improvement of our older generation’s oral health. For elderly patients, ageing itself is an additional factor contributing towards poor oral health, as is systemic disease, weakened immunity and infirmity; the latter of which may contribute towards an inadequate oral hygiene routine.

Oral and dental disorders have a particularly significant impact on patients who are more advanced in years. Whether they are denture wearers, have partial tooth loss or still retain all of their own teeth, for the elderly, a healthy mouth is crucial to their quality of life. With few other distractions, the ability to communicate for social acceptance and interaction, along with enjoyment of food are essential to achieve psychological wellbeing. And of course being able to eat a variety of meals and ingredients increases the likelihood of taking in the right nutrients for optimum overall health.

A lack of oral hygiene, leading to infection, disease and/or pain, has severe repercussions in terms of an older individual’s confidence, dignity and nutritional needs. Unsightly inflammation, bleeding, missing teeth, or sores leading to ill-fitting dentures will knock self-esteem and encourage avoidance of others to prevent risk of embarrassment. But this self-imposed isolation brings a great deal of unhappiness in itself. Evidence also suggests a connection between substandard oral health and serious disorders such as pneumonia in older patients, with those who are hospitalised or in care homes made especially vulnerable.

In addition, older patients are at high risk of suffering from xerostomia, or dry mouth, which seriously enhances the risk of dental disease. As the population ages, they are increasingly likely to be receiving prescription drugs for age-related conditions and, unfortunately, dry

Curasept ADS 0.2% CHX

Conventional chlorhexidine mouthwashes lead to discolouration. Curasept, with its patented Anti Discolouration System (A.D.S.), is proven* to prevent almost all yellow-brown discolouration of the tongue and teeth without altering the anti-plaque and antibacterial action of Chlorhexidine.

*Compare the studies at www.curaprox.com

✔ Alcohol free
✔ Does not alter taste perception
✔ Increases patient compliance

DOES NOT STAIN!

Special promotions available through your dental wholesaler

Follow us on Facebook

SWISS PREMIUM ORAL CARE
mouth is a common side effect for the majority of these medicines. Patients who lack adequate saliva production are more likely to develop infections in the mouth, score caries and have difficulty in eating and speaking — again, having a negative effect on social interaction and nutritional intake.

Healthcare providers can help their elderly patients by asking about their daily oral care habits and recommending hygiene methods to suit their lifestyle. Brushing twice a day with a fluoride toothpaste supported by interdental cleaning may be the mantra of the day, however older patients may lack the necessary dexterity to operate products such as dental floss. By adding an antiseptic mouthwash to their daily oral care, on the other hand, most patients can easily clear more food debris and reduce bacteria in the mouth, helping to prevent gum disease and caries.

However not all mouthwashes are the same. Many still contain alcohol as a key ingredient, which can irritate oral tissues and cause a dry mouth — clearly an unsuitable product both for xerostomic patients and those with sensitive mouths. In addition there remains concern regarding the link between alcohol and oral cancer.

Chlorhexidine (CHX)-based mouthwashes offer patients reassurance simply because they are so effective. CHX is the ‘gold standard’ of active ingredients, scientifically proving its superiority in controlling bleeding, inflammation and sub-gingival plaque over other anti-microbial agents. Research has shown that elderly patients using mouthwash containing 0.12 per cent CHX experienced improved oral health even if they only rinsed once a week.

Unfortunately, chlorhexidine isn’t without its flaws. It has been well documented that many patients using CHX products experience side effects such as altered taste perception and staining of the teeth, gums and tongue; leading to issues with patient compliance. To remedy this, oral healthcare experts have gone to great pains to develop hygiene solutions that patients are happy to use.

Optimum oral health depends upon the successful cleaning of teeth, gums, oral mucosa and dentures; and this must be encouraged amongst our older patients to ensure their remaining years are contented ones. Whether by infirmity or illness, elderly people require more user-friendly oral hygiene products and there is no doubt that mouthwash is straightforward for most individuals to use and, if it is a CHX-based solution, offers considerable protection and guarantees results.
**Probiotics: Bactiotherapy for oral health**

Dr. Rahul Kale, MDS, Dr. Sonal Tambwekar, MDS, Dr. Sunanth, MDS, Dr. A. Sanjay Jain, MDS, Dr. Sharmila Baliga, BDS

**Probiotics** literally means “for life”. They are microorganisms proven to exert health-promoting influences in humans and animals. Probiotics are defined by the World Health Organisation as “live microorganisms which when administered in adequate amounts confer a health benefit on the host”. A recent detailed definition of probiotics is “a preparation of or a product containing viable, defined microorganisms in sufficient numbers to alter the existing microorganisms in the intestine of the host and thereby exert beneficial health effects”. These bacteria have to be the natural flora so as to be able to resist acid and bile, to survive during intestinal transit, to adhere to the intestinal mucosa, and to produce antimicrobial substances in order to retain the characteristics that contribute to their beneficial health effects.

Probiotics must have the ability to inhibit gut pathogens, and they have to be stable during manufacture and storage which can influence both viability and functional properties. A number of bacterial strains have been isolated. However, all do not have the same efficacy. It is important that the potential probiotic strains are well selected prior to use. A combination of strains can enhance adherence in a synergistic manner.

Increase in antibiotic resistant infections due to overuse of antibiotics by physicians has prompted the need to seek safer ways to treat infections.

Recent scientific investigation has supported the important role of probiotics as a part of a healthy diet for human as well as for animals and may be an avenue to provide a safe cost-effective and natural approach that adds a barrier against microbial infection. The use of probiotics in antibiotic resistance is termed as a microbial interference therapy. This concept of microbial ecological change as a mechanism for preventing dental change is an important one since oral infections constitute most common forms of infections in humans. Evidence is now accumulating that probiotics may also play a role in oral ecology. Researchers believe that the probiotics are beneficial for oral health in prevention and treatment of various dental diseases.

History:

1. In 1967, Elie Metchnikoff, a Nobel prize winning Russian microbiologist, first proposed a hypothesis where he suggested that the long, healthy life of Bulgarian peasants resulted from their consumption of fermented milk products. He believed that when taken regularly, the bacteria of milk positively influenced the microflora of the colon, decreasing toxic microbial activity within.

2. In the 1950s, a probiotic product was licensed by the United States Department of Agriculture as a drug for the treatment of scurvy among pigs.

3. The term probiotics which is an antonym to the term antibiotics, was introduced in 1965 by Sir Alex Strachan and S. gordonii within root canal.

The use of probiotics in antibiotic resistance has supported the important role of probiotics as a part of a healthy diet for human as well as for animals and may be an avenue to provide a safe cost-effective and natural approach that adds a barrier against microbial infection. The use of probiotics in antibiotic resistance is termed as a microbial interference therapy. This concept of microbial ecological change as a mechanism for preventing dental change is an important one since oral infections constitute most common forms of infections in humans. Evidence is now accumulating that probiotics may also play a role in oral ecology. Researchers believe that the probiotics are beneficial for oral health in prevention and treatment of various dental diseases.

**Role of probiotics in antibiotic resistance**

1. Role Outcome Strains Reference

<table>
<thead>
<tr>
<th>Role</th>
<th>Outcome</th>
<th>Strains</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plaque control and gingival inflammation</td>
<td>Reduction in plaque accumulation and gingivitis.</td>
<td>Nisin, bacteriocin isolated from L. lactis</td>
<td>K. Noordim and S. Kamm³³</td>
</tr>
<tr>
<td>Periodontitis in smokers</td>
<td>Improvement of plaque index and probing pocket depth from baseline within 8 weeks</td>
<td>L. salivarius WB21</td>
<td>H. Shimauchi et al 2006</td>
</tr>
<tr>
<td>Reduction of malodor</td>
<td>In-vivo and in-vitro study showed a definite inhibitory effect on production of VSC</td>
<td>W. cibaria</td>
<td>Kang et al 2006</td>
</tr>
<tr>
<td>Reduction of malodor</td>
<td>Prevents re-establishment of undesirable bacterial populations and thus help limit the recurrence of oral malodor over a prolonged period</td>
<td>Streptococcus salivarius</td>
<td>Burton JP et al, 2005</td>
</tr>
<tr>
<td>Attachment, adhesion and oral colonization</td>
<td>Co-aggregated with F. nucleatum and thereby forming a barrier that prevents colonization of pathogenic bacteria indicating that probiotics affect formation of oral biofilms and modify resident microflora</td>
<td>W. cibaria</td>
<td>Kang et al, 2005, ³³</td>
</tr>
<tr>
<td>Periodontal diseases</td>
<td>Periodontal dressings with lactobacillus species diminishes the number of periodontal pathogens like Bacteroides sp. Actinomyces sp. and C. alibicans</td>
<td>Lactobacillus species</td>
<td>Volozin et al 2004</td>
</tr>
<tr>
<td>Yeast infections</td>
<td>Rapid decline in C. albicans in mice with a correlation between the highest peak of interleukin-4 and complete eradication of C. albicans</td>
<td>Resident lactobacilli flora</td>
<td>Koll-Klaas et al 2006</td>
</tr>
<tr>
<td>Dental caries</td>
<td>Significant reduction in the counts of S. mutans after 2 weeks</td>
<td>L. reuteri</td>
<td>Caglar et al 2006</td>
</tr>
<tr>
<td>Root canals</td>
<td>Effective at eradicating E. faecalis and S. gordonii within root canal</td>
<td>Nisin, bacteriocin extracted from L. lactis</td>
<td>Turner et al 2004</td>
</tr>
</tbody>
</table>

**Purported mechanisms of action (fig 1)**

Several mechanisms have been suggested to contribute to the action due to probiotics. Probiotics improve colonisation resistance to gut pathogens by reinforcing the mucosal barrier and restoring normal gut micro ecology after diarrhoea. If the intestinal microflora is deficient, antigen transport is increased. Probiotics have been shown to normalise an increased permeability. Binding is considered to be the first step in pathogenesis, and binding the bacteria to intesti- nal mucosa or mucous may allow the colonisation²⁶. Probiotics compete with pathogens for binding sites and available substrates. The rate of progression from inflammation through dysplasia to colon cancer has been seen to be reduced in experimental animals²⁶.

Researchers have shown that the probiotics have bio-therapeutic potential for prophylaxis against the candidiasis. The probiotic bacteria can protect indi- vidual from candidiasis by immunological and non immunological mechanisms²⁶. Probiotics can activate and modulate the immune system²⁶. They reinforce the gut defence by immune exclusion, immune elimi- nation and immune regulation.

**Effects of probiotics on oral health**

Since the mouth represents the first part of the gastrointestinal tract, there is every reason to believe that at least some probiotic mechanisms may also play a role in that part of the system. Mechan- isms of probiotics are drawn entirely from GIT studies; their applicability to oral health needs further studies. It may also anticipate that resident probiotics could exist in the oral microflora. They may function in the complex eco- system of dental plaque and in for- mation and development of oral biofilm in general.

Some hypothetical mecha- nisms of action of probiotics in the oral cavity are discussed here. Probiotics may act by direct or in- direct interaction on oral biofilm and microflora and vice versa³⁵.

Direct interactions may in- clude²³

1. Involvement in binding of oral microorganisms to proteins (biofilm formation).

2. Action on plaque formation and on its complex ecosystem by compromising and intervening with bacteria to bacteria attach- ments.

3. Involvement in metabolism of substrate (competing with oral microorganisms of substrates available).

4. Production of chemicals that inhibit oral bacteria (antimicro-
The new WaterLase iPlus is simply amazing—but don’t take our word for it. Visit AMAZEDBYWATERLASE.COM to see new WaterLase dentists and their first WaterLase patients experience the technology on day one. Get ready to be amazed.

CONTACT US TO LEARN MORE ABOUT WATERLASE IPLUS!
OR VISIT AMAZEDBYWATERLASE.COM TO VIEW INSTANT REACTIONS FROM DOCTORS AND PATIENTS!
Virofex

Heavyweight Disinfection

(Just add water)

Introducing Virofex®, an innovative alcohol-free high level surface disinfection system for use on non-invasive medical devices.

Simply add 500ml of tap water to the system bottle, put one Virofex cartridge into the neck, replace the trigger, shake for a few seconds and it’s ready!

Fresh, perfect strength working solution every time, without any spill hazard or the need for cumbersome and heavy, cumbersome 5L container of conventional disinfectant – and it can be wall-mounted.

Effective

Virofex is highly effective against bacteria, fungi, TRIs, viruses and spores; including MRSA, C-Diff, HIV, Hepatitis and Rotavirus.

Tests have shown that, even after 24 hours, surfaces sprayed with Virofex have a high resistance to contaminating organisms.

Even the dispenser pack itself is bactericidal!

Safe

Virofex is compatible with all surfaces and material types – eliminating the need for different solutions.

Alcohol-free and non-flammable, Virofex does not smell of harmful biocides.

Available exclusively in the UK from
The Dental Directory and Topdental

For more information on this innovative new product, call 01353 652 750 or email sales@virofex.com. Alternatively, watch our demonstration video on YouTube.

www.virofex.com

References: