More Olympians screened for oral cancer

LONDON, UK: Dentists have screened a fifth of all athletes taking part in the 2010 Winter Olympic Games in Vancouver in Canada for oral cancer. Around 800 athletes sat in the dentist’s chair during the competition, with more than 70 dentists and their assistants on hand to practise preventative dentistry in addition to fixing teeth and mouths. Dental associations have welcomed the increased screening campaign that will also educate athletes on the importance of applying sun-cream to help prevent mouth cancers.

The decision to examine 20 per cent of all athletes in the Games was taken by the International Olympic Committee. At the last Winter Olympics in Turin in Italy, only 10 per cent of Olympians were screened for oral cancer. Dental treatment services at sports events like the Olympics usually focus primarily on treating infections and emergency trauma cases involving possible damage to teeth, lips, cheeks and tongues, and broken bones.

Owing to their training conditions, athletes tend to neglect their oral health, according to Dr Jack Taunton, Co-Chief Medical Officer of the Games. He said that they are so nomadic they tend to postpone dental treatment. Some athletes in Nordic events also chew tobacco, which contains numerous carcinogens that can cause oral cancers. In addition, the reflection of ultraviolet radiation off snow and ice increases the risk of developing skin and lip cancers.

“You have to consider they are exposed to these intense ultraviolet rays for up to 50 years, through their training and post-competitive coaching years. The skin on the lips is thin and poorly protected,” said Dr Chris Zed, Associate Dean of Dentistry at the University of British Columbia and Co-head of Dental Services for the 2010 Winter Games.

He added that the danger is cumulative and could lead to the development of oral cancer later in life.

(Edited by Daniel Zimmermann, DTI)
Anti-tobacco programme set up in Indian dental clinics

Country also needs national policy on oral health, IDA Secretary-General says

Currently, almost half a million people in India die from oral cancer each year, mainly because they chew or smoke tobacco. Dr Dhoble, who spoke to reporters at Dentists’ Day celebrations in Fort Kochi in Southern India in early March, said that if detected at the right time, those cases could be not only treated, but also prevented. He demanded the introduction of a national oral health policy by the Union government. He said that even though most dental diseases could be treated, the number of people in the country suffering from these conditions is so large that it was not possible to treat even half of them. Treatment costs are too high and many regions lack sufficient manpower, he said.

According to the latest statistics from India’s Ministry of Health, nearly 70 per cent of children in urban areas have dental decay and over 80 per cent of adults suffer from gum disease. A national policy would complement the Association’s programmes in order to reduce the high figures of oral diseases, including oral cancer, Dr Dhoble added.

Public dental clinics in Singapore charge for missed appointments

NHG dental clinics have seen a growing number of patients lately. In 2008, almost 70,000 patients sought treatment, which is an increase of more than 10 per cent compared to 2007. However, four out of 10 patients failed to keep their appointments, wasting slots that could have been used for patients who require treatment.

In the past, telephone messages were left and reminder letters were sent to patients a few days before their dental appointments, a NHG spokesperson said. Patients were also sent SMS messages, but these measures did not yield a “positive improvement”, he added.

Public dental clinics like those of the NHG group operate on an appointment-only basis. Walk-in cases are also attended to but only after the patients with appointments have received treatment. Not showing up on the designated date means that other patients are deprived of an earlier appointment. Waiting times are typically between three months and half a year.

Other clinics have declined to charge for missed appointments.
Swiss implant group invites dentists to Geneva symposium

Daniel Zimmermann

LEIPZIG, Germany: The International Team for Implantology (ITI) has announced that it will discuss new clinical methods for diagnosis and treatment planning at its upcoming World Symposium in Geneva, to be held from 15 to 17 April 2010. The forum, which is open to implant specialists worldwide, will be complemented by two full-day pre-Symposium courses on soft-tissue management and bone grafting. Simultaneous interpretation will be provided from English into 12 other languages, including Chinese, Japanese and Korean, the organiser said.

This year’s meeting, which also marks the 30th anniversary of the organisation, will be held for the 11th time. More than 100 experts from 25 countries are expected to attend the event. For the first time, the meeting will also be accompanied by an industry exhibition.

The Swiss-based ITI is an independent academic organisation dedicated to the promotion of evidence-based research in the field of implant dentistry. They also focus on the development of comprehensive treatment guidelines such as the ITI Treatment Guide series, which is claimed to be substantiated by extensive clinical testing and successful long-term results. Furthermore, ITI funds research and provides scholarships to young clinicians.

According to their own figures, the organisation currently has 7,000 members and divisions in over 24 countries.

Metal foam takes stress off implants

Claudia Salwiczek

NEW YORK, USA/LEIPZIG, Germany: A newly developed metal foam that mimics the natural structure of bones could help to prevent the rejection of biomedical body replacements such as dental implants. The composite material, which is made out of 100% steel and aluminium, is lighter than solid titanium and has an extraordinarily high-energy absorption capability, a paper by researchers at the North Carolina State University reports. In addition, the modulus of elasticity of the foam has been proven similar to that of bone.

Modulus of elasticity has been demonstrated as extremely important for biomedical implants. When a dental implant is placed in the body to replace a bone, it needs to manage the loads in the same way as the surrounding bone. If the modulus of elasticity of the implant is much larger than the bone, the implant will take over the load bearing and the surrounding bone will start to die, a process called stress shielding.

“Our foam can be a perfect match as an implant to prevent stress shielding,” said Dr Afsaneh Rabiei, Associate Professor of Mechanical and Aerospace Engineering at NC State and co-author of the paper. “The rough surface of the metal foam will also bond well with the new bone formed around it and let the body build inside its surface porosities.”

He concluded that through these features, mechanical stability and strength of implants inside the body could be significantly increased in the future.
Dear reader,

When GSK recently announced that it is to remove zinc from their denture creams, there was outcry from customer protection agencies around the world. Almost at the same time, a website in the US warned that asbestos fibres found in some dental products can be harmful to dentists. No outcry was heard from the dental community.

Similar to most health professionals, dentists have to face an array of hazards in their daily working lives. These are in the form of not only infectious diseases, but also substances found in dental materials and equipment that pose health threats to dentists. Although these threats are not acute, studies have demonstrated that long-term exposure has the potential to damage their health.

Dentists traditionally place much trust in manufacturers, mainly because they have became comfortable using a certain product throughout their career and are hesitant to change. However, they should become more aware that they too are customers and if something seems odd, questions should be raised.

If products can be made safer for the health of the masses, they can certainly be made safer for professionals.

Yours sincerely,
Daniel Zimmermann
Group Editor
Dental Tribune International

Claudia Salwiczek

Two weeks ago, the 21st Winter Olympics ended with the passing on of the Olympic torch from Vancouver to Sochi in Russia. All the excitement and records aside, what remains are images of many athletes failing at their respective disciplines. Never before have the Games pushed the physical limits of what the human body can accomplish. Sadly, one athlete from Georgia lost his life after leaving the track at high speed during the men’s luge competition.

One major issue overshadowed by these tragedies is oral health. It seems that athletes and officials alike are not paying much attention to this problem, maybe because a healthy mouth and teeth are not considered relevant to top performance. This assumption is certainly wrong. Pain resulting from tooth decay, root-canal infection or gum disease can trouble athletes to such an extent that they are not able to compete. In addition, UV radiation accumulated over a long time in sports like the biathlon or cross-country can significantly increase the risk of developing oral cancer.

The International Olympic Committee’s decision to screen more athletes for oral lesions this year is a step in the right direction and an acknowledgement that oral health forms part of general health. However, having these examinations every four years won’t change much in the general oral-health behaviour of athletes. Dentists, physicians and training staff need to drive home to them that a little investment in their mouths will help to remain more healthy not only during their active career, but also later in life.

Let’s hope that the competition for better oral health will already have begun when the Olympic flame shines over Sochi in 2014.

Claudia Salwiczek is working as specialty editor for Dental Tribune Asia. She can be contacted at c.salwiczek@dental-tribune.com.
Haiti receives further support at Midwinter Meeting
Dental coalition agrees on measures to help victims of quake disaster

Javier M. de Pison
DT Latin America

CHICAGO/MIAMI, USA: The president of the Haitian Dental Society, Dr Samuel Prophet, has asked US dental associations and professionals for support to rebuild the public health system of his country and to give help to colleagues whose offices have been destroyed. Dr Prophet, who was invited by the Chicago Dental Society to join this year’s Midwinter Meeting, spoke at the opening session of the Chicago Midwinter Meeting as part of an initiative of Dental Tribune Latin America to help colleagues in Haiti following the 12 January earthquake.

“The people of Haiti will forever be grateful to the international dental community for the aid received in shelters and makeshift refugee centres in the form of hygiene kits with toothbrushes, toothpaste and soap, and for the volunteer dentists who have gone to help, along with their Haitian colleagues, to bring assistance to the needy,” said Dr Prophet. He added that this tragedy would also give the opportunity to honour its victims by assisting in the mammoth task of rebuilding Haiti.

Officers of the American Dental Association (ADA) also held a meeting requested by Dental Tribune Latin America to seek solutions to the crisis in Haiti, specifically to help colleagues who have lost family members, offices and their means of work. At the ADA headquarters in Chicago, ADA President Dr Ronald L. Tankersley, President-elect Dr Raymond Gist, Executive Director Dr Kathleen T. O’Loughlin and Director of the Division of Global Affairs welcomed an international delegation that included Dr Prophet, Dr Adolfo Rodriguez, President of the Latin American Dental Federation (FODA), Dr Adán Yáñez, President of the Ibero-Latin American Dental Federation (FDILA), Torsten Oemus, President of Dental Tribune International, and Javier de Pison, editor of Dental Tribune Latin America.

The group discussed different ways to help Haiti, such as the Oral Health Coalition for Haiti and other initiatives like conferences at various congresses in Latin America and the US, a programme called Adopt a Dentist, and collaboration with companies for the donation of materials, instruments and dental units.

Dr Yáñez offered to devote one day of the FDILA congress, to be held from 12 to 16 May 2010 in Puerto Vallarta in Mexico, to Haiti. On this day, which will be entitled A Smile for Haiti, prominent Latin American

spokesmen will donate their lecture fees. Amongst the confirmed speakers are Drs Miguel Asenjo (Dominican Republic), Sergio Kohren (Argentina) and Enrique Jadad (Colombia). In addition, the FDILA will host a gala dinner to raise funds and is offering discounts to commercial exhibitors who sponsor events or donate materials to Haiti.

As assistance, A Smile for Haiti will be broadcast live through the Dental Tribune Study Club (DTSC), an online educational platform. This initiative will enable dentists in Latin America who wish to help to sign in and view the presentations by renowned specialists. The nominal fee charged for signing in will be donated to a fund for Haiti. A week prior to the Mexico event, the DTSC will present a series by English-language speakers with the same purpose.

(Edited by Daniel Zimmermann, DTI)
Asbestos fibres may harm dentists too

Daniel Zimmermann

NEW YORK, USA/LEIPZIG, Germany: According to the US website Asbestos.net, dentist should be more aware of the hazards arising from asbestos. High concentrations of the microscopic fibres are often found in treatment rooms, from where they can penetrate the lung and cause mesothelioma, a rare and inoperable form of cancer that develops from the protective lining of the body’s internal organs. Annually, 20,000 people die of the condition around the world.

High exposure to asbestos is common in trades such as construction, in which there is the danger of inhaling the carcinogen’s dust and fibres from plaster and other asbestos-containing products. In dentistry, the minerals are often used for the lining of casting rings or dental tapes. Dentists are at risk because they usually work in small confined rooms and do not take precautions against inhaling the fibres.

Recent studies have found that daily occupational exposure over time, even at low asbestos levels, under poor ventilation conditions in a closed space could cause pleural lesions.

The website said that symptoms of the tumour’s presence are usually not evident for another 20 to 50 years. They advise dentists who think they may have been exposed to asbestos to monitor their health carefully in conjunction with a physician.

Limit staff access to drugs

Robin Goodman

TUCSON, USA: Dental offices and the pharmaceuticals used there present the risk of drug abuse, but dentists can put policies in place that help reduce the chance of illegal use of controlled substances, according to an article in Anesthesia Progress (2009, 56:112–115).

Dr Joel M. Weaver writes that dentists who place too much trust in their employees make themselves and their practices vulnerable to people who abuse controlled substances. Dentists who regulate drug access and distribution are protecting more than their patients, employees and reputation. While it’s often easier to stick with the way things have traditionally been done, making a few changes to drug-access policies makes good business sense, Dr Weaver says.

“Although change is difficult and usually meets with resistance, the thoughtful practitioner who can step back and observe her or his practice for potentially fatal weaknesses will be less likely to succumb to a disaster,” Dr Weaver writes.

“Accredited hospitals already have strict rules to help prevent drug theft, but private unaccredited offices without mandatory policies are protecting more than their patients, employees and the pharmaceuticals used in their employees make them-long in their employees make them-

Dr Weaver writes.

“Accredited hospitals already have strict rules to help prevent drug theft, but private unaccredited offices without mandatory controls are highly vulnerable to drug theft and deception.”

By taking sole responsibility for storing, filling and handling syringes containing controlled substances, dentists can reduce the chance of illegal drug use or mistaken dosages. It’s important to rely only on those licensed to handle medications, Dr Weaver says, such as physicians, dentists, nurses and pharmacists. Other employees who receive on-the-job training may be more likely to make mistakes with drug dosages and concentrations.

“Who should have access to controlled substances in the dental office? The answer is simple: only licensed professionals and as few of them as is reasonable,” he says.

(Edited by Daniel Zimmermann, DTI)
The new Elcomed from W&H: logical and easy to use. Uncompromising in performance: with a torque of up to 80 Ncm on the rotating instrument, the surgical drive unit guarantees smooth usage, which can be completely documented at no further cost thanks to an integrated USB interface. These are just three of the many advantages of the new W&H Elcomed.
SciCan merges with SycoTec, MICRO-MEGA
New dental conglomerate announces to strengthen market presence in Asia

Daniel Zimmermann
DTI

NEW YORK, USA/LEIPZIG, Germany: In one of the largest industry mergers this year, the Canadian-based manufacturer of infection-control products SciCan has announced its amalgamation with the German—French conglomerate SycoTec, MICRO-MEGA. With a combined workforce of 800 staff and offices in Canada, France, Switzerland and Germany, the new company will form one of the ten largest dental groups worldwide. The finacial terms of the agreement have not been disclosed.

Company officials said that the merger is not a buy-out and that all three companies will remain independent under one umbrella. Mergers-related downsizing is not intended, but SciCan’s German office in Augsburg will be closed and its 25 employees relocated to the future company headquarters in Leutkirch-Aligau in Germany.

SycoTec, which specialises in dental drives and motors, bought the French manufacturer of root-canal instruments MICRO-MEGA in October last year. The former subsidiary of KaVo has been under pressure lately, owing to a decline in demand in local and international dental markets. According to an article in the newspaper Schwäbisches Tagblatt, orders in early 2009 decreased by 40 per cent, forcing the company to place almost two-thirds of its employees on short-time.

SycoTec CEO Dr Martin Röckert confirmed that the merger would not only help to prevent lay-offs, but also promote further growth. The latest merger with SciCan is intended to complement the current offering of surgical and endodontic instruments with a full range of infection-control products. “We now can offer dentists and doctors a ‘one-stop shop’, from instruments to materials to the entire reprocessing system,” he said.

Both companies intend to make use of each other’s exist ing distribution networks in North America and Europe and strengthen their market presence in Asia.

Dr Röckert, who will lead the new company with SciCan’s current Chairman Arthur Zwengenberger, added that most of the positions within the organisation will be filled with existing personnel to avoid unnecessary costs. Although the name for the new organisation is still under discussion, the merger is expected to become legally effective within the next few months, he said.

Straumann goes fully digital at Midwinter Meeting

Sierra Bendon
DTA

CHICAGO, USA/LEIPZIG, Germany: Straumann is advancing its position in the dental market as a provider of comprehensive digital implant and restorative solutions. At the Chicago Midwinter Meeting, which was held 25-27 February, the company revealed its new digital platform Straumann Digital Solutions. The new brand combines computer-guided surgery, intra-oral imaging and CAD/CAM prosthetics under one umbrella. According to the company, it will first be available to dentists in the USA.

In addition to the new system, a new CAD/CAM system, with a new scanner, was launched in Chicago. A number of new products and features, including veneers, inlays and onlays, will also be introduced to the market over the course of the year. Gilbert Achermann, President and CEO, commented: “Digitalisation will impact all aspects of dentistry as digital workflows supersede labour-intensive manual processes, enhancing inter faces, shortening treatment, reducing potential for error and improving quality assurance.”

“Straumann is committed to bringing the new technologies to customers as part of an integrated array of flexible, reliable solutions that are designed to optimise workflows and enhance patient care,” he added.

Straumann entered the field of computer-guided surgery in 2009 with the acquisition of IVS Solutions, a German company specialising in software applications for computer-guided surgery, including surgical template design and fabrication. In the same year, the company also signed a distribution agreement for iFero, an intra-oral scanning system made by US manufacturer Cadent.

Straumann already has a CAD/CAM offering that includes scanners, software and a full range of prosthetics in modern bio-compatible, durable and aesthetic materials through its partnership with Ivoclar Vivadent. The SafeTouch Rejuvenate Nitrile Plus, which complements the company’s extensive medical glove offering, is enriched with lanolin, vitamin E to nourish, moisturise, soothe the skin.

According to Medicom, they are soft and durable while offering excellent tear strength and puncture resistance. The gloves are also fully textured to ensure enhanced grip in wet conditions. Improved ergonomics ‘latex like’ feel allows precise movement reducing hand fatigue, they added.

(MT WOUDENBERG, The Netherlands: Allergic reactions have become a major health concern for both patients and healthcare workers who frequently use latex gloves. In addition, every time a healthcare worker takes off his/her examination gloves, washes their hands and then puts on another pair of gloves, they become predominantly vulnerable to dry, rough, irritated and cracked skin. Medicom says to have found a solution to both problems by introducing the SafeTouch Rejuvenate Nitrile Plus to all major markets.

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Dr Howard Marsh, Chief Medical Officer at GSK Consumer Healthcare, commented, “The safety of our consumers is our primary concern. We are taking this action because we have become aware of potential health problems associated with the long-term, excessive use of our zinc-containing denture adhesive products. These reports are rare, given that several million people worldwide are users of the products.”

He said that patients who use denture creams on a daily basis should consult their doctor and switch to a zinc-free alternative. The use of too much adhesive might indicate ill-fitting dentures.

GSK will effect transition to zinc-free versions of all affected variants worldwide up to April this year. The label zinc-free will be clearly displayed on the new packaging, the company told Dental Tribune Asia Pacific.

GlaxoSmithKline removes zinc from denture creams

Daniel Zimmermann
DTI

LEIPZIG, Germany: Owing to consumer reports alleging neurological complications with long-term use, GlaxoSmithKline (GSK) has announced that zinc will be removed from its denture cream brands worldwide. The British manufacturer also warned consumers of the potential health risks associated with long-term, excessive use of zinc-containing denture adhesives and said that these products remain safe to use as directed on the product label.

Zinc was originally added to denture adhesives to improve its adhesive strength. Recent studies, however, have demonstrated that excess amounts of the metal can accumulate over time, resulting in paralysis of some patients. Health experts recommend 8 milligrams of zinc per day for women and 11 milligrams for men. Denture creams contain up to 38 milligrams of zinc per gram.

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From news reports

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(Edited by Daniel Zimmermann, DTI)
## PROVEN FACTS

<table>
<thead>
<tr>
<th>ACTION</th>
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| Inhibition of caries in an animal model                                | ✓  Reynolds et al., 1995  
                                           (J Dent Res, 14, 1272-1276) | ?                               |
| Inhibition of dentine demineralisation in vitro                        | ✓  Yamaguchi et al., 2007  
                                           (Caries Res, 41, 204-207)  
                                           Rahiots & Vougiouklakis, 2007  
                                           (J Dent, 35, 695-698) | ?                               |
| Promotion of dentine remineralisation in vitro                         | ✓  Rahiots & Vougiouklakis, 2007  
                                           (J Dent, 35, 695-698) | ?                               |
| Inhibition of plaque formation in situ                                 | ✓  Reynolds et al., 2008  
                                           (J Dent, 36, 272-281) | ?                               |
| Inhibition of enamel demineralisation in situ                          | ✓  Reynolds, 1987  
                                           (J Dent Res, 66, 1120-1127)  
                                           Reynolds, 1998  
                                           (Spec Care Dentist, 18, 8-16) | ?                               |
| Promotion of enamel subsurface lesion remineralisation in situ         | ✓  11 publications including  
                                           Shen et al., 2001  
                                           (J Dent Res, 35, 2066-2070)  
                                           Iijima et al., 2004  
                                           (Caries Res, 38, 551-556)  
                                           Manton et al., 2008  
                                           (Int J Paediat Dent, 18, 294-290) | ?                               |
| Inhibition of caries progression and promotion of regression of caries in a randomised controlled clinical trial | ✓  Morgan et al., 2008  
                                           (Caries Res, 42,171-184) | ?                               |
| Promotion of enamel subsurface lesion remineralisation in a randomised controlled clinical trial | ✓  Bailey et al., 2009  
                                           (J Dent Res, Submitted) | ?                               |

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**FDI “official relations” status with World Health Organization**

**Renewed at 126th Executive Board Meeting**

The Executive Board of the World Health Organization (WHO) renewed FDI’s status as a “non-governmental organization (NGO) in official relations” during its 126th session in Geneva, Switzerland from January 18-23. FDI’s incoming Associate Director and Head of Public Health, Dr. S.D. Shanmuganathan, and Manager of Public Health and Advocacy Projects, Jon Crail, attended the meeting, together with representatives from the World Health Professions Alliance (WHIPPA).

The Executive Board session opened with a report by Director-General, Dr Margaret Chan, highlighting key issues for discussion throughout the weeklong series of meetings, including an update on relief efforts in Haiti, the accomplishments and ongoing challenges towards achieving the WHO Millennium Development Goals, and acknowledgement of the effective international response in containing the new H1N1 virus to date. (A complete version of Dr Chan’s report is available on the WHO website: www.who.int.)

The decision by the Executive Board Standing Committee on Nongovernmental Organisations to renew the status of FDI World Dental Federation as an NGO in official relations” was based upon reports submitted by FDI outlining previous and current work plans related to public health. Notably, the Committee recommended recognising the contributions and continued support of FDI in the achievement of WHO’s objectives. FDI representatives followed discussions on a number of other agenda items relevant to oral health and dental practice, including the drafting of a global code of practice for the international recruitment of health professionals, implementing a strategy for preventing and controlling non-communicable diseases (of which oral health-related illness is the most common chronic disease), and ongoing monitoring of the progress towards WHO’s Millennium Development Goals.
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Brushing off Dentin Hypersensitivity

Proper Technique Helps Prevent Potential Oral Problems

Dentin hypersensitivity is described clinically as a short, sharp pain due to exposed dentinal tubules responding to a variety of external stimuli which includes thermal, osmotic, mechanical, evaporative, and tactile stimuli.

Common treatment modalities usually involve prevention of the occurrence of nerve stimulation by either occluding the dentinal tubules or altering the nerve stimulation process. Reduction or elimination of risk factors, which include appropriate behavioral conditioning among others, is also an integral component of managing dentinal hypersensitivity.

The exposure of dentinal tubules is generally attributed to the loss of tooth substance, both enamel and cementum. One of the factors contributing to the surface loss is poor tooth brushing technique. If done injudiciously, toothbrushing, the very activity designed to protect the health of the dentition, may actually be a significant factor in undermining the tooth structure and, in consequence, oral health, itself.

Vigorous and horizontally directed strokes particularly on the gum area can wear a v-shaped abrasion on the neck of the tooth. This will render a large number of dentinal tubules exposed and open to the oral environment and the fluids inside vulnerable to rapid pressure changes which in turn elicit nerve response perceived as a painful sensation by the patient.

Behavioral modification coupled with the use of "tissue friendly" soft toothbrush and gentle toothpaste may significantly prevent the unnecessary exposure of dentinal tubules. Using soft-bristled tooth brush, the patient may direct the tufts at a 45-degree angle around the gum area and apply deliberate but gentle sweeping strokes along the tooth surface towards the incisal or cuspal surfaces. The gum area should also be covered in the gentle brushing to aid in enhancing tissue stimulation and blood circulation for a more improved health of the gingiva.

Brushing the teeth correctly, at least twice a day, with fluoride-containing toothpaste may help provide the individual with an acid-resistant protective layer. And in case of the onset of symptoms of dentinal hypersensitivity, one may find relief by using hypersensitivity relieving paste. In search of such appropriate relief, scientific advancements are directed towards the use of natural existing ingredients and more natural ways of relieving dentin hypersensitivity (e.g. sealing or occluding the dentinal tubules with calcium and phosphate rich materials).

As reported a more recent technological breakthrough paved the way towards the development of a toothpaste which is clinically proven to provide immediate and lasting relief from dentin hypersensitivity with the use of a naturally occurring amino acid found in saliva.

A two-minute brushing is said to be sufficient to clean the different surfaces of the dentition. It is just like enjoying your favorite music while doing something after savoring your favorite dish or meal. Undoubtedly, it is also like brushing off a potential problem like dentinal hypersensitivity while enjoying an after-meal personal hygiene activity towards a healthy smile.
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6 Docimo R et al J Clin Dent 2009; 20 (Spec Iss): 137-143

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“Patients demand instant aesthetic results”

An interview Dr Sim Tang Eng, President of the Asian Academy of Aesthetic Dentistry

In your opinion, how important is continuing education in the field of cosmetic dentistry?

Very important! In fact, I strongly believe that all dental professionals who profess to practise aesthetic or cosmetic dentistry must keep up-to-date with the developments in dental materials, technology and clinical techniques, as this clinical discipline changes dynamically and rapidly.

They have to possess knowledge of sound scientific theories and clinical practice. They owe it to their patients who entrust them with the responsibility of providing quality aesthetic dentistry. This is only possible if the dentists keep abreast of developments through continuing education.

What options for continuing education are available for Asian dentists?

There are basically two options available. Firstly, besides the biannual AAAD meetings, dentists can attend the numerous scientific meetings and hands-on workshops organised regularly by the various national aesthetic dentistry organisations in the Asian region. Those who are really eager can attend the meetings organised by the International Federation of Esthetic Dentistry, American Academy of Esthetic Dentistry and American Academy of Cosmetic Dentistry. These are excellent meetings but dentists will have to travel great distances to the meeting venues.

Secondly, dentists can attend the structured programmes organised by universities. Several US universities offer courses, on part-time or full-time basis, tailored aesthetic dentistry. In addition, it is extremely important for dentists to read journals and textbooks regularly in order to enrich their knowledge. I find that most dentists want to take the easy route by depending only on lectures and fellow colleagues for information.

What brings you to this interview?

In order to become a member of AAAD, one must hold a university dental degree. Alternatively, dentists can become a member through the institutional membership of an aesthetic dentistry organisation in one of the member countries, or privately. The AAAD aims to have all member countries register as institutional members in order to simplify the logistics of keeping track of membership records.

The organisation’s 14th biennial meeting is going to be held in May. What objectives would you like to see fulfilled?

In accordance with the objectives of AAAD, the main objective will be the promotion of the art and science of the disciplines in aesthetic dentistry. This year’s biennial meeting boasts some of the best speakers and clinicians in aesthetic dentistry in the world. It is very difficult to book them and we therefore want to keep our lecture schedules way in advance.

This meeting will be a golden learning opportunity for our colleagues in Asia, particularly in Malaysia. I hope it will foster greater understanding amongst Malaysian and other Asian dentists, besides providing an opportunity to experience the excellent scientific meetings that AAAD organises biennially in this region.

I am sure it will be an eye-opening and rewarding experience to see and hear the level of aesthetic dentistry presented by our four keynote speakers. In the process, I hope attendees will be inspired and never look at aesthetic dentistry the same way again.

What makes you and your colleagues go to these meetings in the Asian region?

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“Asians have followed trends in the West when it comes to demands in aesthetic dentistry”

I certainly think this is the way forward. The AAAD can act as an accreditation body by recognising them as having achieved a certain acceptable standard. Driven by patient demand, the field of aesthetic dentistry has gained much prominence in recent years. What are the current trends in aesthetic dentistry in Asia? With greater exposure to the media and the Internet, as well as increasing affluence, Asians have followed trends in the West when it comes to demands in aesthetic dentistry. Just ask any dentist who has been practising aesthetic dentistry long enough. It is not uncommon to have patients coming into the office with close-up photographs of Western models or film stars with the request to have their teeth done the same way.

Increasingly more patients now choose veneers or have their teeth bleached in order to obtain their ideal set of sparkling white teeth. The preference for full-ceramic crowns instead of the traditional porcelain-fused-to-metal crowns is definitely on the rise for obvious aesthetic reasons. The trend for quick fix with veneers or crowns in midly crowded dentition instead of conventional orthodontic treatment is also gaining in popularity, especially amongst working adults.

Patients demand instant aesthetic results with the least amount of interference in their lives. Even in orthodontics, I understand that patients request invisible braces. More patients are also aware of the appearance of their gingiva instead of just their teeth and this has invariably resulted in increasing demand for periodontal plastic surgery as well. The list goes on and on.

What is perceived as an attractive smile in Asia? I think the general rules governing an aesthetic smile apply universally. Tooth proportion of the anterior teeth is generally the exception. Asians tend to have narrower anterior teeth, i.e. lower width-to-length ratio compared to Caucasians. I think the general rules governing an aesthetic smile apply universally. Tooth proportion of the anterior teeth is generally the exception. Asians tend to have narrower anterior teeth, i.e. lower width-to-length ratio compared to Caucasians.

What are the current trends in aesthetic dentistry? As witnessed at all major dental exhibitions last year, digitalisation is the new trend in dentistry. What has the effect of this increasing digitalisation been? It certainly is a boon to the practice of aesthetic dentistry. It makes communication and presentation much easier. The archiving of clinical photographs, which is of utmost importance, is now an easy task thanks to digitalisation.

What are your plans for the future? My term as the AAAD President ends with my handing over of office to Prof Hisashi Hisamitsu at the biennial meeting this coming May. I will continue to contribute in whatever way I can to the progress of the AAAD, particularly in the areas of sharing my clinical knowledge with the various national aesthetic dentistry organisations. I will remain active in my clinical practice, as I believe one can only teach and share meaningfully if one has the experience and regular practice.

Thank you very much for the interview.
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Anne Levitch
Australia

There are many benefits to refurbishing or relocating your dental practice, and although the decision to make such major physical changes to your surgery is usually secondary to other financial concerns, most practitioners find that they receive more than the obvious benefits with a new surgery. The opportunity to streamline the operation of your practice and attract new patients can be immensely profitable to your business. By increasing the functionality of your surgery, the productivity of your staff will improve. Patients will also feel more comfortable in a fresh, well-organised, private practice.

After about ten years, the furnishings and fittings in most dental practices become worn. Fashions also change—to such an extent that even the most stylish design in 2000 can simply highlight the age of your practice today. Patients expect a clean, modern surgery design and associate it with the highest standards in healthcare. Most commercial leases are for five years, so the end of your second lease is often a convenient time to consider relocating your practice. Generally, the life of your equipment is also about ten years, considering changes in technology and the availability of spare parts.

The main factors involved in the decision regarding a new surgery are room for expansion, practice image, privacy for patients and staff, movement and functionality, standards of hygiene, and the age of equipment. Relocating to larger premises allows for the expansion of your surgery and the facilities to take on more staff, and therefore, more patients. Space adjoining your existing premises may be available, and awareness of such opportunities is worthwhile.

Should you update the overall image of your practice during refurbishment, you could address aspects such as the finishes, graphics, visibility, staff image and the facilities in your practice. Major refurbishment or relocation gives you an opportunity to overhaul the image of your practice, which can help you attract potential patients and retain existing ones. The traffic flow in your practice should allow for easy movement by staff and patients, whilst maintaining the privacy of both. Refurbishing gives you the opportunity to redesign the layout of your practice, and make better use of the space available. Moving into a new space means your surgery can be designed based on the knowledge of your previous layout—as benefits and disadvantages.

Moving into a new space means your surgery can be designed based on the knowledge of your previous layout—its benefits and disadvantages. Your practice will ensure a higher standard of infection control with a new fit-out and streamlined surfaces to clean. An advantage of relocation or a major refurbishment is the opportunity to upgrade equipment and reassess storage needs. The size and accessibility requirements of new equipment and storage can be integrated into the design of a new practice.

Relocation carries a greater financial risk than refurbishment, owing to the time it may take to secure new premises and an increase in short-term expenses, but this is usually outweighed by an increase in business. Fitting out a new space also eliminates the inconvenience of an interruption to the operation of your surgery, as you can continue practising in your old premises until the new space has been finished.

Should you consider relocating your surgery, start looking around commercially for suitable premises in your area 18 months in advance, in order to better determine the range of spaces available and learn of future opportunities. Looking ahead of time will help you to secure a space that is appropriate and affordable for your new surgery. Should you inform agents and owners that you are looking for premises, these opportunities may come to you.  

Anne Levitch has managed Levitch Design Associates, a healthcare design business, for over 25 years. She can be contacted at info@levitch.com.au.

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The access and quality agenda in the slums of India

Dr Seema Sharma
UK

When I heard that 6,000 children die every day in India, my responses were WHAT! WHY? Isn’t India an emerging economy? Growing up in sub-Saharan Africa (Zambia) I had seen poverty, but I had never appreciated that India had 20 times the population of the UK and 160 times the population of Zambia: one billion in Africa—47 governments, 1.2 billion in India—one government, not easy.

It is no surprise then that when I was approached in the Autumn of 2009 to participate in the UK Channel 4 series Secret Millionaire I felt compelled to say yes. I meet dentists and doctors from the Asian sub-continent every day, and we often wonder how many of us owe our success to our brave ancestors who migrated in search of a better life and to the opportunities that Britain offered us. I also meet many dentists and doctors who are not from the Asian subcontinent, who want to give time and love to those less fortunate in Africa and Asia, for example through Bridge2Aid.

Some really bizarre thoughts went through my mind when I first arrived in Dharamv, the largest slum in South-east Asia. It houses 1.2 million people in 1 square mile; in fact 60 per cent of Mumbai’s residents live on 6 per cent of Mumbai’s land. I wanted to pick some of those helpless children up and cuddle them—but what were their local child protection policies? I wanted to pull them away from the flying glass in the recycling areas—where was their health and safety policy, let alone risk assessments and safety glasses?

It got worse. The dumping ground was a cesspit, swarming with flies, sewage, animals and people. Not much infection control going on here; HTM 01-05 wouldn’t get a look in. Slips and trips policy? Well in a nutshell: try not to slip or trip when the bulldozers come to the dump to make space for more garbage, you will get hurt.

We in the UK are just waking up to the fact that one year is a challenging timetable for us to meet the standards of the Care Quality Commission. What would happen if the Care Quality Commission came to the slums?

The experience changed my life. I sat in a comfortable space back home in London—I under
stood Delivering Better Oral Health and care pathways in dentistry; we risk assessed our patients in East London and targeted high-needs patients with preventive advice, fluoride and fissure sealants. Dental disease was preventable and I was used to driving on about sugar intake and cleaning habits, and spending hours on toolkits. National Health Service contracts and secondary school entrance exams were the only frustrations, but both were getting better.

I certainly won’t be waiting for the ABC before numbers, and I did not teach my kids to write boxes on ‘quality’ as we know it, but what were their local child protection policies? I wanted to pull them away from the flying glass in the recycling areas—where was their health and safety policy, let alone risk assessments and safety glasses?

Not so, little was I to know that I would fall in love with the sensibilities and sensitivities of the social entrepreneurs I met in Mumbai.

Whilst I couldn’t tick the boxes on ‘quality’ as we know it, I saw incredible strength in the teamwork and resilience of charity workers determined to make a change in India, and I was overawed by the personalised care, respect and support people living and working in the slums showed for each other and for me, a total stranger. How could I have believed that India should have fed its poor before it developed its space programme? What can India do to help its poor unless it creates riches with which to help them? I did not teach my kids to write the ABC before numbers, and I certainly won’t be waiting for registration with the Care Quality Commission. I have learnt not to judge what I see in India, but to accept it as it is, with its multiple social and commercial facets, and many cannons firing simultaneously.

India is cited as one of the BRIC economies by Goldman Sachs, and Indians are deservedly proud and work hard for what they have. However, it requires foreign investment, an influx of wealth, and a speedier pace of development to help its people. Go India! You are now a home to 17 per cent of the world’s population; you need a measurable share of the world’s wealth to care for them. Otherwise, 6,000 children will die every day for some time to come.

“I was overawed by the personalised care, respect and support people living and working in the slums showed for each other and for me”

The Honey and Mumford learning styles questionnaires, I come up strongly pragmatic, not an activist, not a theorist, not a reflector. I expected to go to India, get some sanitation and education projects going and come home feeling good.
Health care spending has improved but still lies below average. (DTI/Photo Michael Jung)

Australia less than average in health care spending

**LEIPZIG, Germany:** Asian countries have been found to spend less of their GDP’s for health care than most other countries in Europe and the US. According to a new health care report by the Organisation for Economic Co-operation and Development (OECD) in Paris, only New Zealand provided more money for health care than the average of all observed countries. Japan, Korea and Australia, however, spent less than the OECD average of 8.9 percent of GDP.

The US currently spends more on health care than any other country—almost two and a half times greater than the OECD average of US$2,984, adjusted for purchasing power parity. Luxembourg, France and Switzerland also spend far more than the OECD average. At the other end of the scale, healthcare expenditure in Turkey and Mexico is less than one-third of the OECD average.

The latest edition of Health at a Glance demonstrates that all the countries observed could do better in providing good health care. Key indicators presented in the report provide information on health status and the determinants of health, including the growing rates of child and adult obesity, which are likely to drive higher health spending in the coming decades.

Based on new data on access to care, the report demonstrates that all OECD countries provide universal or near-universal coverage for a core set of health services, except the US, Mexico and Turkey.
1+1=3

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