Implant dentistry in Singapore gets boost

University of Washington endorses six-month course in surgical training

Daniel Zimmermann

While dental education programmes between Singapore and other countries already exist, this is the first time that a US university has endorsed a training programme offered by a private dental clinic in the country. Besides consultation on the programmes, UW will also provide training and assessment on UW’s main campus in Seattle for the final part of the course.

“Singapore is hugely important and recognised as a key dental and health hub for Asia and we are delighted to partner T32 Implant Dental Training Centre to provide a robust course for dentists to continue their specialist postgraduate training, post graduate which in turn will benefit patients in Singapore and across the region,” commented Dr Ariel Raigrodski, Associate Professor and Director of Graduate Prosthodontics at UW’s Department of Restorative Dentistry. Singapore’s Chief Dental Officer Prof. Patrick Teong hailed the new partnership, which he said would provide more opportunities for dentists to update their knowledge and offer better quality dental care. Patients who may not be able to afford treatment with the latest dental techniques will also benefit from the new programme, as they will be given treatment at a reduced cost treatment by qualified dentists under the guidance of the T32 Centre’s trainers, he added.

Singapore has seen an upswing in the number of placed implants placed lately due to rising income placed and higher oral-health awareness amongst the population. Dr Wong Keng Mun, Managing Director of T32 Dental Centre (middle), surrounded by staff (DTI/Photo courtesy of Max PR, Singapore)

Stem cell bank opens in Mumbai

Health care consulting company Generali Strategic Services in India has announced its partnership with a French biomedical institute to open the first dental stem cell bank in Mumbai. The new company Stemade Biotech will use a patented technology from Institute Clinident BioPharmain Aix-en-Provence in France to extract and preserve Dental Pulp Stem Cells derived from primary and wisdom teeth under cryogenic conditions for various therapeutic applications in the future, company officials said.

The latest research has indicated that adult stem cells, which can also be extracted from bone marrow and other parts of the human body, have the potential to treat non-communicable diseases like cancer or heart disease and to repair or regenerate entire organs. Dental Pulp Stem Cells have been found to form at least 29 different unique tissues, including dental enamel, dentin, bone, blood vessels and nerve cells.

UAE kids miss out on dental checks

The head of Dubai Dental Services of the United Arab Emirates’ (UAE) Ministry of Health Dr Aisha Sultan has called on the central government in Abu Dhabi to increase spending on preventive oral-health programmes. She said that while other Middle Eastern countries like Bahrain have successfully implemented such programmes, the UAE still lacks political will to introduce regular dental checks of schoolchildren, especially in the country’s neglected Northern rural areas.

According to the results of a national oral health survey conducted in early 2010, caries is highly prevalent in the primary dentition of most five-year-old children living in the UAE. It also found that only 17 per cent of all children were complete caries free.

Dental corp sends help to Pakistan

Henry Schein, the largest dental company in the world, has donated health care supplies to the flood victims in Pakistan. The effort is part of the company’s global social responsibility programme that supports non-governmental organisations during humanitarian emergencies.

NZ reptile tested for use in dentistry

UK researchers have started to investigate the sophisticated interplay between jaws, muscles and the brain through skull and teeth of a NZ reptile species called Tuatara. Their studies could help to prevent damage to dental implants and jaw joints that occur after loss of periodontal ligament.

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Aussi coalition agrees on more spending for dental care

Daniel Zimmermann

HONG KONG/LEIPZIG, Germany: The new coalition between the Australian Labor Party and the Australian Greens is giving greater priority to dental services. In a policy agreement signed by the new Prime Minister Julia Gillard (Labor) and Green Senator Bob Brown in September, party leaders agreed to raise more money for dental services in the 2011 federal budget.

The commitment is seen as a first step in establishing a universal dental health care scheme, which has been in high demand by dentists and patients alike.

After two weeks of political deadlock, Labor recently regained power by winning support of Green Members of Parliament to form a minority government against the Liberal-National Coalition. During the federal election campaign, senior Australian dental officials had criticised the lack of political commitment to oral health across the political landscape and urged all parties to come up with new ideas regarding improving access to dental health care services in the country. (Please see ‘Australia: Oral health at stake in federal election’ Dental Tribune Asia Pacific, No. 7+8, 2010: 1).

Australian Dental Association (ADA) leader Dr Neil Hewson has welcomed the new agreement as an overdue step to improving federal funding for dental care. He said that his organisation will be open to discussing new initiatives like the ADA’s own Dental Access scheme that aims to improve access to dental services for disadvantaged groups and people living in neglected rural areas, where patients often have to wait weeks or months for a dental appointment.

Malaysia opens advertising market for health professionals

Daniel Zimmermann

HONG KONG/LEIPZIG, Germany: Malaysia is currently liberalising provisions under the Sales and Advertising Act that will allow health care providers to advertise their services in all media. Restrictions placed on advertising abroad are also to be removed, according to the Ministry of Health. Under the previous act, medical advertisements, including websites, had to receive prior approval by the Ministry of Health’s Medicines Advertising Board (MAB). Advertisements, including websites, had to be shortened from six weeks to approximately a few days.

Currently, all medical advertisers, including websites, have to receive prior approval by the MAB. Advertisements containing false information can be rejected or even incur a penalty of up to RM3,000 (US$725), or imprisonment of one or two years.

Malaysia’s Health Minister Datuk Seri Low Tiang Lai told reporters that the government had decided to remove the ban to promote the country’s growing medical tourism market and raise the number of foreign patients from the current 350,000 to over 550,000. He said that although medical advertisements still require approval from the ministry’s Medicines Advertising Board (MAB), waiting times will be shortened from six weeks to approximately a few days.

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India sets new World Record in oral health, heads for another
Daniel Zimmermann

HONG KONG/LEIPZIG, Germany: Indians have set a new World Record for the Most People using Mouthwash at the same time. Guinness World Records recently acknowledged the achievement that saw over 300 people line up and rinse their teeth simultaneously during a World Oral Health Day charity drive in Mumbai.

Indian Dental Association (IDA) officials, who organised the event in cooperation with dental products manufacturer Listerine, said that the successful record attempt was held to carry oral health messages around the country, where most people only use a toothbrush but avoid additional oral care measures such as mouthwash or dental floss. They said that the organisation has also teamed up with Colgate, another large manufacturer of dental products, to set a new record for the most dental checkups delivered in one day. The event will take place during Oral Health Month in dental camps around New Delhi and Mumbai, and will be joined by Indian actresses Karisma Kapoor and Shriya Saran.

Philippine government investigates lab closure
Daniel Zimmermann

HONG KONG/LEIPZIG, Germany: The Philippine Department of Labor and Employment has started investigations into the sudden closure of a dental facility in the capital Manila that left over 400 workers jobless. The lab, which has been operating under the name Skytech International Dental Laboratories, was allegedly shut down due to bankruptcy over e-mail by its American owner in late August and without prior notice to management and staff, Filipino newspapers report.

Skytech has produced dental replacements, including crowns, bridges and dentures for clients in the Philippines and abroad.

The Department took up investigations after members of the leftist Bayan Muna party filed a resolution during a September parliamentary session that urged the government to immediately look into the matter and “craft measures to prevent similar incidents and ensure the protection of workers’ rights in this age, where major management decisions are relayed and implemented via electronic means.”

Department of Labor and Employment Secretary Rosalinda Baldoz announced it would request domestic and US governmental support to file legal action against the missing owner, who currently resides in the US. She also said that her Department would provide financial compensation to former Skytech employees and discuss measures regarding resuming operations, including the formation of a workers’ cooperative to handle unprocessed local and foreign orders.

Canadian investor Frontier Corporation is rumoured to have an interest in taking over Skytech’s business operations in the Philippines.

Besides other countries in Southeast Asia, the Philippines have become an important hub for the production of dental replacements that cost a minimum there to make, compared to laboratory work produced in Europe or the US.
Dear reader,

Are you looking for a new dental lab? Well, just step into your front yard and you will find plenty of them.

There is no doubt that denture making has become a flourishing business in the region, particularly in South East Asia. In countries like the Philippines, Thailand and Vietnam, there are now large facilities producing huge amounts of low-cost dental work not only for dentists in Singapore or Japan but, increasingly, overseas.

However, low prices often come at a high cost. In this case, it’s the technicians who do not only earn significantly less for doing exactly the same work as their Western counterparts but who also have to cope with poor working conditions. Dentists should remember this next time they consider sending an order to Manila or Hanoi.

Don’t get me wrong, dental work made in Asia CAN be of high-quality. In these small but economically growing countries, where the middle class is constantly expanding, there is a large clientele for high-end dental care. But try to find the differences in working conditions. Dentists should remember this next time they consider sending an order to Manila or Hanoi.

Don’t get me wrong, dental work made in Asia CAN be of high-quality. In these small but economically growing countries, where the middle class is constantly expanding, there is a large clientele for high-end dental care. But try to find the differences in working conditions. Dentists should remember this next time they consider sending an order to Manila or Hanoi.

Two separate worlds of dentistry exist in Australia. Headly accessible, highly quality dental services for high-income Australians are supported by over a billion dollars of federal spending via insurance rebates and uncapped programmes for baby boomers with the personal resources to negotiate medical funding for those with chronic diseases. Middle and low income Australians, the majority of the population, face either affordability barriers for private dentistry or a scarcity of resources for public dentistry barely maintained by state and territory governments. This is an unfair and unjust situation.

Policy directions have been proposed, not the least by the National Health and Hospitals Reform Commission in 2008 and 2009. The holdest proposal was a universal social insurance scheme for dental services. While its costs, community or professional support might be debated, what seems irrefutable is the need to decide on a long-term direction for financing reform and make an immediate start on an incremental implementation. The insurance proposal was accompanied by policy on a dental graduate residency year, a revitalisation of dental services for children and an investment in oral health promotion, which have all less controversial, but also stalled.

While the universal dental insurance scheme seemed to be stalled by professional opposition and its full implementation cost, the recent Australian federal election has brought all the former proposals back to life. Specifically the Australian Labor Party has been forced to agree to “urgently further action on dental care … in the context of the 2011 Budget” in an agreement with the Australian Greens so as to form the new Gillard minority government. Similar interest in dental care has been shown by the ‘cross-bench Independents’ who have also been crucial in determining who governs Australia.

The hope is that the Gillard Government will pursue a similar approach to other contentious policy areas and form a ‘working group’ under the Federal Cabinet with all parties, the Independents represented and a small number of experts to drive policy in the lead up to the 2011 Budget. It is not beyond Australians to develop detailed policy that could steer a path through competing self-interests and arrive at improved oral health and fairer access to dental services in Australia. :)

Yours sincerely,

Daniel Zimmermann
Group Editor
Dental Tribune International

The politics of a dental plan for Australia
One in five Italian dentists not qualified to practise

Daniel Zimmermann
DTI

LEIPZIG, Germany: A large number of dentists and dental technicians in Italy are practising illegally. According to estimates from the National Association of Italian Dentists (ANDI), approximately one in five or a total of 15,000 dentists are not qualified to practise. The organisation admitted that there might be over 1,000 bogus dentists in Rome alone.

Practising dentistry without being qualified to do so is common in Italy, with many clinics and practices operating undetected for many years—even decades. In September, police raids in Palermo and three other cities found at least seven clinics that employed dentists who were not qualified to practise dentistry. However, only very few unqualified dentists are prosecuted. Last year, fewer than 500 people were charged with the unauthorised practice of the dental profession, according to police reports.

ANDI said that most illegal dentists are able to practise dentistry through diplomas gained from countries that recently entered the EU or from South American countries, where educational standards are generally lower. The penalty for the unauthorised practice of dentistry in Italy is six months’ imprisonment or a fine of €500 to 600.

Nano paint fights off superbacteria

Claudia Salwiczek
DTI

NEW YORK, 3/8/A/LEIPZIG, Germany: The emergence of antibiotic-resistant bacteria is becoming a major challenge in the fight against hospital-related infections. Researchers from New York and Albany in the US have now reported the successful testing of a new nanoscale coating that can be used for surgical equipment or hospital walls and that kills even super-resistant bugs like Methicillin-resistant Staphylococcus aureus (MRSA) within 20 minutes of contact.

MRSA is a bacteria strain usually found on the skin and sometimes nasal passages of healthy people from where it can make its way into the body through cuts or medical equipment accessories like catheters and breathing tubes. Infections caused by MRSA are difficult to treat because they do not respond to antibiotics used to treat staphylococcus infections, such as penicillin or cephalosporin. In countries like Australia, more than 700 patients die of MRSA-related infections each year.

The new coating, which is based on a natural enzyme called lysostaphin, can be used with any type of surface finishes, the researchers said. It is only toxic to MRSA and works by first attaching itself to the bacterial cell wall and then killing it by slicing it open.

“It’s very effective. If you put a tiny amount of lysostaphin in a solution with Staphylococcus aureus, you’ll see the bacteria die almost immediately,” said Prof. Ravi Kane, Department of Chemical and Biological Engineering at the Rensselaer Polytechnic Institute in Troy, New York. “At the end of the day, we have a very selective agent that can be used in a wide range of environments—paints, coating, medical instruments, door knobs, surgical masks—and it’s active and it’s stable.”

Kane added that the coating has a dry storage shelf life of up to six months and can be washed repeatedly without loss of effectiveness.

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Experts discuss dentine hypersensitivity at forum

Daniel Zimmermann

SALVADOR DA BAHIA, Brazil/LONDON, UK: Experts in the field of dentine hypersensitivity gathered last month at the FDI’s Annual World Dental Congress in Salvador da Bahia, Brazil, to discuss the latest developments and updates in managing the condition.

Prof. Martin Addy, lecturer at the University of Bristol’s School of Oral and Dental Sciences in the UK, set the scene by considering the accepted definition of hypersensitivity and possible reasons for the condition. He described the history of the profession’s knowledge of dentine hypersensitivity as “An enigma being frequently encountered but ill-understood”, quoting Johnson et al. (1982). Although there has been an awareness of the condition for more than 100 years, much is still unknown about it.

To define dentine hypersensitivity, Prof. Addy looked to Holland et al. (1997): “Dentine hypersensitivity is characterised by short, sharp, pain arising from exposed dentine in response to stimuli, typically thermal, evaporative, tactile, osmotic or chemical and which cannot be ascribed to any other form of dental defect or pathology.” He commented that it is very difficult to diagnose sensitivity clinically, as sensitive and non-sensitive dentine look similar at the level at which a clinician sees dentine.

Prof. Addy described the most accepted theory for hypersensitivity—hydrodynamic theory. Explaining the hydrodynamic mechanism in relation to the teeth, he referred to a study in which a sensitive tooth and a non-sensitive tooth were analysed. It demonstrated that the sensitive tooth had eight times the number of tubules, and that the tubules themselves were twice the diameter of those in the non-sensitive tooth.

Next to speak was Prof. Nicola West from the University of Bristol Dental Hospital. In her presentation, Dentine hypersensitivity: The importance of patient factors, she looked at the aetiological factors for hypersensitivity. She highlighted the behavioural effect of dentine hypersensitivity on patients whose quality of life is impaired by the condition. Prof. West focused on the issue that dentine needs to be exposed to cause hypersensitivity and that the exposure is mainly caused by gingival recession, compromise of gingiva by periodontal disease or enamel erosion.

Gingival recession is often caused by trauma to the margins, usually by the vigorous brushing of the sufferer. Prof. West advised looking at patients’ toothbrushes and their brushing methods when seeking a cause for hypersensitivity, but did caution that this may be difficult, as patients will modify their behaviour when being observed.

Prof. West also discussed enamel erosion at length. She explained the difference between intrinsic (i.e. gastro-oesophageal reflux disease) and extrinsic (i.e. acid challenges...
caused by food and drink) erosion. In considering extrinsic erosion, she focused on the acidic challenges to teeth as a result of the diet of a hyper-sensitivity sufferer. Many of the problems appear to stem from the number of acidic drinks available. According to 2009 sales figures for soft drinks in the UK, a staggering 229.1 litres of soft drinks are consumed per person per year; that’s 0.65 litres a day! For a person susceptible to erosion, this can present a significant acidic challenge to teeth.

Prof. West called for routine screening for tooth wear and erosion, especially in face of the rise in patient and tooth longevity and the availability of treatments to help reduce the severity of the sensitivity for patients. She also listed some recommendations for patients: reduce frequency of acid exposure; avoid acidic foods and drink at night-time; no swishing or frothing drinks around the mouth; avoid brushing teeth directly after an acidic challenge.

The next presentation was by Dr Stephen Mason. His presentation, Sensodyne Rapid Relief—instant and long-lasting protection, detailed the latest GSK product offering to combat sensitivity. Dr Mason detailed the different formulations of Sensodyne in the past using strontium chloride and the particular challenges this presented, namely a taste many consumers disliked and non-compatibility with fluoride.

Strontium chloride was then surpassed by strontium acetate because of its compatibility with fluoride, non-staining properties and improved taste. This has now been developed into a marketable product called Sensodyne Rapid Relief. Dr Mason discussed some of the clinical research that has been conducted for the Rapid Relief product, first against a fluoride control toothpaste and then against a competitor brand using 8% arginine calcium carbonate. The studies demonstrated that there was a marked reduction in pain felt by the subjects both after immediate application with a pea-sized amount directly to the tooth, and after set periods of time brushing twice a day. In nearly every study, the group using Rapid Relief demonstrated the most improvement.

Prof. Tinoco then discussed treatment adjuncts, both for patients at home and clinical interventions in surgery. Clinical treatments included the use of varnishes and primers; the use of glass ionomers to cover the affected area; laser treatments or mucogingival surgery.

He concluded that there should be proactive screening of all patients to help with correct diagnosis. Advising patients about diet modification etc. should help remove or modify the severity of the sensitivity, and the recommendation of brushing with a desensitising toothpaste twice daily, as well as rubbing it on affected areas is an extremely efficacious, low-cost, non-invasive treatment.

A good starting point for managing hypersensitivity in practice once a correct diagnosis has been made and other causes have been excluded or treated, said Prof. Tinoco, is the identification of aetiological factors and their exclusion by means of diet modification or oral-health instruction. Other factors he discussed beyond those already mentioned in previous presentations included occupational factors, such as the damage sustained by competitive swimmers and professional wine-tasters. Obviously, wine piqued the attention of many attendees!

Prof. Tinoco explained the way in which to taste wine properly: “To experience the taste of a wine fully, swirl a little bit of it in your mouth to cover all your taste-buds. Take a moment to enjoy the flavour before either swallowing or spitting out the wine. In addition to the initial taste, you will find there is also an aftertaste to the wine, usually referred to as the finish.”

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Canadian dentists in favour of local labs

Daniel Zimmermann

TORONTO, Canada/LEIPZIG, Germany: Fewer dentists in Canada are having their denture prescriptions fabricated in the US or offshore, according to a new survey by the Dental Industry Association of Canada (DIAC). Of 1,000 dentists who participated in the survey, only 2.3 per cent sent their prescriptions outside the country—a decline of 4.6 per cent compared with the 2008 survey.

Dentists who responded to the DIAC questionnaire saw “consistent quality” and “better communication” as the main factors in choosing dental labs. Pricing as a factor ranked second place after being a leading factor for two consecutive years. Faster case turnaround was the third highest ranked factor in the survey.

According to the Canadian Dental Association, there were slightly over 2,000 dental technicians working in the country’s couple of hundred dental labs in 2009. Despite a drop in the number of tooth extractions performed by dentists and the promotion of dental health, the number of dental technologists, technicians and laboratory bench workers has increased slightly in recent years, owing to the development of new types of prostheses that require more work.

Universal nano hybrid restorative launched by VOCO

LEIPZIG, Germany: The German manufacturer of dental materials VOCO is launching a new universal nano hybrid restorative for all cavity classes in October. Grandio®SO can be used for a wide range of indications including class I to V restorations, the reconstruction of traumatically injured anterior teeth or the correction of shape and colour to enhance aesthetic appearances. Interlocking and splinting of loosened teeth, core build-up for crowns, and the fabrication of composite inlays are other indications covered by the material, the company said in a press release.

According to CEO for Marketing and Sales, Olaf Sauerbier, Grandio®SO is currently the most tooth-like material on the market due to its physical parameters and their interaction. He said that the composite’s very high filler content, low shrinkage, as well as high compressive and flexural strength will dentists help to achieve durable and, at the same time, aesthetic restorations. The material is also offering improved thermal expansion behaviour, a very high surface hardness as well as an optimal balance of translucence and opacity, he added.

Grandio®SO has shown to combine exceptionally long workability under exposure to light with very short setting times (10 seconds per 2 mm increment) during subsequent polymerization. It also exhibits good plasticity without tending to stick to the instruments.

Grandio®SO comes in 16 different shades including two new shades (VCA3.25, VCA5), which according to Sauerbier have been in demand for a long time. It is available in the form of rotating syringes and caps.

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“We are committed to investing and supporting the development of implant dentistry in China”

An interview with Beat Spalinger, President and CEO of Straumann, Switzerland

The Swiss-based dental manufacturer Straumann recently announced that it is extending its reach into the Chinese dental market. At Sino-Dental 2010 in Beijing, Dental Tribune China Senior Editor Edward Chen spoke with the new President and CEO Beat Spalinger about the company’s plans and commitment to China.

Edward Chen: Mr Spalinger, your company is planning to set up a sub-division in China. What lies behind this decision and will it influence your business strategy there?

Beat Spalinger: China is currently the key growth market in Asia for dental implants or any type of restorative dentistry. There is increasing demand for top quality dental solutions combined with education and service in the country and we have been committed to supporting our customers in the region through our Asian head-quarters in Singapore. So far, the Chinese dental community has responded very positively to this.

However, with the rapid growth of implant dentistry in China, we need to get closer to our customers and strengthen our local presence. Therefore, we have decided to not only continue the partnership with Beijing Focus Medical, but also open our own subsidiary within this business year. Having our own local representation will allow us to understand the needs of our Chinese customers better and to play a more active role in key professional activities such as educational programmes and workshops.

Owing to the global economic slow-down, some dental markets have experienced a decline in the past two years. Why do you consider China as holding good prospects?

Even though China is still at a relatively early stage in implant dentistry, the continuous growth of public institutions, together with the rise of the private sector, give us reason to believe that China will be one of the top three markets globally in the next ten years.

We are committed to investing and supporting the development of implant dentistry in China, focusing on scientific evidence, training and educational activities. This commitment is also reflected in the establishment of Straumann China.

Do you have a long-term commitment to the Chinese market?

Straumann has gained some considerable market share in the past two years that has been driven by our innovative and clinically proven line-up of products and technologies. I am proud to say that we are one of the very few companies, if not the only company, to have an implant system on the market that is supported by ten years of clinical data.

We also believe that our commitment to training and education such as sponsoring implant training centres in Beijing and Hong Kong, or the recently held First International Periodontology Congress in Hangzhou has contributed significantly to our success in China.

Together with Beijing Focus Medikal we will continue to seek to gain the trust of dental professionals who wish to offer their patients optimum treatment solutions.

What is Straumann’s current product line and do you plan to launch new products this year in China?

We recently launched our third-generation implant surface technology SLActive, as well as our new generation Bone Level Implant range. We also have other offerings like the high performance material Roxolid and our digital solutions portfolio, which have just been launched in initial markets and are to be rolled out globally as soon as possible.

Could you tell us more about SLActive and your new Bone Level Implant?

SLActive has been shown to increase treatment predictability by enhancing osseointegration and reduce healing times from 6–8 to 3–4 weeks which makes it superior to other major competitor implant surfaces.

The Straumann Bone Level Implant offers new confidence at bone level through optimised crestal bone preservation, simplified handling (thanks to the new CrossFit Connection), and excellent aesthetic results due to improved soft-tissue management. It complements our highly successful Tissue Level range and enables us to offer a complete system for all indications that can be used with the same surgical kit. We expect the full launch of the Straumann Bone Level Implant later this year in China.

An increasing number of Chinese dentists seem to be incorporating implant dentistry into their practice. How do you think Straumann could support them?

To help dental professionals achieve predictable long-term aesthetic outcomes, Straumann engages in a wide range of educational activities across all specialisations. Last month, for example, we held the ITI Education Week at the University of Hong Kong, which was unique in being organised in partnership with the International Team for Implantology (ITI) network in Switzerland. ITI will also hold its first Congress in China in Inner Mongolia in August next year.

In addition, Straumann and ITI are supporting their customers by educating patients through various educational material and scholarships that are intended to enable young dentists to study at universities abroad for a semester. The ITI also funds research currently being conducted at Chinese universities.

Thank you very much for the interview.
Removal of a fractured instrument: Two case reports

Dr Rafaël Michiels
Brugge

Fractured instruments pose a challenge to every endodontist. The difficulty in the retrieval of these instruments ranges from surprisingly easy to downright impossible. The clinical outcome of cases with fractured instruments depends on several factors, such as the position of the instrument in the canal, the type of material, the instrument size and canal anatomy. Failure in retrieval of the fractured instrument does not automatically result in failure of the case. Once can still try to bypass the instrument, choose a surgical approach, or even wait and see. However, if we hear ‘nothing ventured, nothing gained’ in mind, then we should always at least try to retrieve the fractured instrument.

Case I

A 27-year-old female patient was referred to our practice. She was in good health and had an American Society of Anesthesiologists (ASA) score of 1. The patient had some mild clinical symptoms on tooth #30 due to apical periodontitis. She had been told, by the referring dentist, that there was a fractured instrument in her tooth and that the instrument had to be removed first in order to allow for decent retreatment.

Before starting with the treatment, a new diagnostic radiograph was taken. In this case, the diagnostic radiograph (Fig. 1) showed not one but two broken instruments in the mesial root, one in each mesial canal. Thereafter, the tooth was isolated with the rubber dam and the coronal filling was removed. Straight-line access was established, as this is imperative in order to be able to reach and see the fractured instruments. Gates-Glidden burs (DENTSPLY Maillefer) were used to enlarge the mesial orifices coronally.

After reaching the instrument in the mesio-buccal canal, I modified a Gates-Glidden bur by removing the tip of the bur (Fig. 2). In this manner, one gains an aggressive bur that allows one to create a platform above the instrument. At this moment, the instrument could be clearly visualised (Fig. 3). Ultrasonics were then used to loosen the fragment. A modified Gates-Glidden bur (DENTSPLY Maillefer) was used to enlarge the mesial orifices coronally.

One-and-a-half hours after starting the treatment, the fragment had been loosened but was still stuck in the canal. We decided to leave it in place for the time being and made a new appointment. Calcium hydroxide paste was used to create a platform above the instrument. Calcium hydroxide paste was removed, using 10% citric acid and passive ultrasonics with the BBRAFE tip (Sateltec). Again, ultrasonics were used to retrieve the instrument. After five minutes, the fragment in the mesio-buccal canal was removed. Another five minutes later, the instrument in the mesio-lingual canal was also removed. While removing the instrument in the mesio-buccal canal was very time-consuming, removing the instrument from the mesio-lingual canal was surprisingly easy. This clearly highlights the aforementioned difficulty range of instrument retrieval.

After the removal of both instruments, working length was determined in both mesial canals with the electronic apex locator (Root ZX Mini, Morita). A glide path was established and the mesial canals were initially shaped with a ProTaper S1 (DENTSPLY Maillefer). CO2 coolant irrigation was performed using 5% sodium hypochlorite. Next, the gutta-percha in the mesial canal was removed with a size 25.06 ProFile (DENTSPLY Maillefer), which was rotated at 500 rpm in an X-smart Easy endodontic motor (DENTSPLY Maillefer). No chemical was required for gutta-percha softening. The canals walls were scraped with Micro-Debriders (DENTSPLY Maillefer) in order to remove the last remnants of gutta-percha. All canals were shaped to a size 40.06 ProFile. Final apical shaping was performed with K-Flexofils (DENTSPLY Maillefer). smear layer removal was carried out by new irrigation of the canal with 10% citric acid. A final wash of the canal was performed with sterile saline. Tapered gutta-percha cones were then fitted.

During the next visit, the tooth was again isolated and opened. A gutta-percha point was removed, using 10% citric acid and passive ultrasonics with the BBRAFE tip (Sateltec). Again, ultrasonics were used to retrieve the instrument. After five minutes, the fragmented instrument in the mesio-buccal canal was removed. However, it was stuck in the canal. We decided to leave it in place for the time being and made a new appointment. Calcium hydroxide paste was used to create a platform above the instrument. Calcium hydroxide paste was removed, using 10% citric acid and passive ultrasonics with the BBRAFE tip (Sateltec). Again, ultrasonics were used to retrieve the instrument. After five minutes, the fragment in the mesio-buccal canal was removed. Another five minutes later, the instrument in the mesio-lingual canal was also removed. While removing the instrument in the mesio-buccal canal was very time-consuming, removing the instrument from the mesio-lingual canal was surprisingly easy. This clearly highlights the aforementioned difficulty range of instrument retrieval.

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A diagnostic radiograph, showing two separated instruments in the mesial root.—Fig. 2: A modified Gates-Glidden bur used for creating a plateau above the instrument.—Fig. 3: One of the separated instruments.—Fig. 4: Gutta-percha cone filling.—Fig. 5: The pulpal chamber after obturation with gutta-percha.—Fig. 6: Final radiograph (parallel).—Fig. 7: Final radiograph (angled).—Fig. 8: Diagnostic radiograph, showing the separated instruments at approx. 3 mm from the apex.—Fig. 9: The separated instrument.—Fig. 10: The separated instrument.—Fig. 11: Working length determination.—Fig. 12: Deep apical split.—Fig. 13: Gutta-percha core filling.—Fig. 14: Final obturation with gutta-percha.—Fig. 15: The pulpal chamber after complete obturation with gutta-percha.—Fig. 16: Final radiograph (parallel).—Fig. 17: Final radiograph (angled).
Occlusion was performed according to the continuous wave of condensation technique with the Elements Obturation Unit (SybronEndo). After occlusion (Fig. 5), a temporary restoration of glass-ionomer cement was placed (Fuji IX GP Fast). Final

Case II

A 19-year-old male patient was referred to our practice. He was in good health and had an ASA score of 1. The referring dentist had fractured a small instrument—most likely a size 10 or 15 K-file, according to his referral letter—while performing root-canal treatment on tooth #4. After opening, the remnants of calcium hydroxide paste were removed with 10 % citric acid and passive ultrasonics. The fractured instrument could be visualized immediately (Fig. 6), because the canal was very large in the middle and coronal part. This allowed a very conservative and tissue-saving approach. Given the position in the canal and the shape of the canal, a deep apical split of the canal was suspected. After probing with small K-files, a patent palatal was confirmed.

The instrument was fractured in the buccal canal. A titanium Prot/Itra tip #8 (DENTSPLY Maillefer) was used to loosen the instrument. In the meantime, cuspid irrigation with 5 % sodium hypochlorite was performed.

The fractured instrument was retrieved (Fig. 10) and after determining working length (Fig. 11), shaping with rotary nickel-titanium instruments (Twisted Files, SybronEndo) was started. Both canals were shaped to a size 25.08. Smear-layer removal was performed with a rinse of 10 % citric acid. A final wash of the canal was carried out with sterile saline. Tapered gutta-percha cones were then fit-ted and tug-back was confirmed (Fig. 13). Topseal was used as a root-canal sealer. Both canals were obturated according to the continuous wave of condensation technique with the Elements Obturation Unit. After obturation (Figs. 14 & 15), a temporary restoration in glass-ionomer cement was placed together with a cotton pellet, which was soaked in an alcohol and chlorhexidine mixture first and then air-dried after it had been placed in the access cavity. Final radiographs (Figs. 16 & 17) were taken, both parallel and angled. The prognosis of this case was good and the patient was referred to his local dentist for a definitive coronal restoration.

Conclusion

In the end, removal of a fractured instrument can be very difficult and it may take a long time to accomplish. Dr Marga Ree once said on the ROOTS forum that patience is all about the three Ps: Passion, Persistence and Paitence. This hits the nail right on the head as far as instrument retrieval is concerned.

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

Contact Info

Dr Rafael Michiels works in two private practices limited to Endodontics in Belgium. He can be contacted at rafael.michiels@gmail.com
Obtaining harmonious aesthetic results with two different veneering materials is a considerable challenge that is not without risks. Situations in which dental technicians are forced to use several different veneering materials to satisfy the needs of their customers are determined by biological factors and the financial means of the patients. All the ceramic veneering materials on the market differ in their chemical composition, which is responsible for the final appearance of the restoration. In addition, the influence of the framework material should not be underestimated. If it hinders the transmission of light, the aesthetics of the restoration will be compromised.

So, how do we obtain truly perfect results?

We tend to choose products that can be combined on the basis of their optical compatibility. For this purpose, we often have to rely on the many years of experience we have gained working with materials from different manufacturers. However, we have also found that we can achieve optical compatibility by using products from manufacturers who supply materials that are coordinated in terms of their shade. Manufacturers who focus their efforts on solving the problem of optical compatibility amongst their different materials strive to offer their products in integrated systems.

On the basis of the following case, we would like to demonstrate the manner in which two different materials can be successfully combined. The patient’s teeth #14, 15, 16, 17, 26 and 27 were restored with provisional crowns. For the permanent restoration of these teeth, a combination of all-ceramics (IPS e.max, Ivoclar Vivadent) and PFM ceramics (IPS InLine, Ivoclar Vivadent) was chosen: metal frameworks veneered with the leucite-based feldspathic ceramic IPS InLine were combined with lithium-disilicate glass-ceramic frameworks veneered with the nano-fluorapatite glass-ceramic IPS e.max Ceram.

The patient chose this solution for financial reasons. In the fabrication of the restorations, the specifications of the shade diagram and the recommended layer thicknesses of the individual materials were observed. The latter aspect was of particular importance due to the different shrinkage characteristics of the two ceramics.

The individual IPS InLine and IPS e.max Ceram veneering materials (for example, Dentin, Incisal and Effect materials) not only have consistent designations, but also coordinated shades. Before the metal frameworks in the present case were veneered with IPS InLine, the substrate had to be completely covered with an opaquer layer to mask the metal. The IPS e.max lithium-disilicate frameworks did not require this coating, as the materials for the fabrication of the substructures are available in many different shades and levels of translucency.

Nonetheless, we were able to follow the same shade diagram once we had placed the layer that would mediate the required adhesive bond (after foundation and opaquer firing, respectively). This enabled us to obtain the desired harmonious appearance of the restorations. IPS InLine and IPS e.max Ceram differ slightly with regard to their translucency. However, this aspect is quite useful in the subsequent layering procedure. We attenuated and masked the opaque-ness of the metal frameworks, while we enhanced the translucent properties of the lithium disilicate by applying the IPS e.max Ceram all-ceramic.
instructions of the manufacturer: the IPS e.max Press lithium-disilicate frameworks with a minimum final thickness of 0.8 mm and the metal frameworks (Co-Cr alloy) with a thickness of minimum 0.4 mm. Both types of restorations were built up anatomically, that is, with supported cusps and crown margins, in order to obtain an even thickness of the veneers. This detailed wax-up provides the basis for creating restorations with maximum aesthetics and function. Next, the sprues were attached to the wax-ups (Fig. 1).

After the press and casting procedures, the substructures were coated with a wash and opaquer layer respectively in preparation for the subsequent layering procedure. The metal frameworks were completely masked with opaquer (Fig. 2) and shoulder powders were evenly sprinkled onto this layer. The excess was carefully removed. This step improves adhesion and optimises light refraction through the crystals of the Margin material.

This effect attenuates the opaqueness of the PFM restoration. It is clearly visible in the finished restoration.

We followed a similar procedure for all-ceramic substructures. If the framework had to be (partially) shaded, we used IPS e.max Ceram shades instead of the opaquer. The remaining surfaces were coated with a thin layer of glazing liquid. Then we used the sprinkle technique to distribute IPS e.max Ceram Dentin over the frameworks. In the fabrication of restorations with lithium-disilicate substructures, the achievement of light scattering is secondary. Rather, the focus for this type of restoration is on adhesion. After firing, the surfaces are slightly rough, which mediates the desired bond between the framework and the layering material.

In the present case, the metal-reinforced crowns were built up first. Owing to the versatility of all-ceramics, the desired harmony with regard to shades and opaqueness is easier to achieve with these materials than with PFM materials. In order to obtain an overall aesthetic result, therefore, the all-ceramic restorations were fabricated last (Fig. 5). Figures 4 and 5 show the finished crowns on the model with the gingival contour. The adhesive luting composite Multilink Automix (Ivoclar Vivadent) was used to cement all the crowns. This luting composite is suitable for the cementation of PFM and all-ceramic restorations.

The present case demonstrates that the combination of PFM ceramics and all-ceramics can produce excellent aesthetic results. Coordinated materials and shade systems make it easy to use different types of ceramics in one restoration and allow materials such as the Effect materials to be used to their fullest effect. With the help of conventional shade diagrams, the desired results can be achieved quickly and easily.

Replace missing teeth within the aesthetic zone in an aesthetically satisfactory fashion has been and still is a major challenge in dentistry. High esthetic expectations and the required materials and shade systems make it easy to use different types of ceramics in one restoration and allow materials such as the Effect materials to be used to their fullest effect. With the help of conventional shade diagrams, the desired results can be achieved quickly and easily.

Dr Christian Coachman received his dental degree from the University of São Paulo and his dental technology certificate from Paulista Medical School (São Paulo, Brazil). He completed a dental ceramic specialization program and opened his own laboratory in 1996. From 1996 to 2004, he worked as a technical consultant at Dentifix, São Paulo. He is a founder of and has been a lecturer at the Insight Group Ceramic Training Centre (Brazil, USA) since 2003. He is a member of the Brazilian Society of Esthetic Dentistry. From 2004 to 2008, Dr Coachman was the head consultant of Tooth Alerte consisting of Dr Ronald Goldstein, Dr David Garber and Dr Maurice Salama. He has invented and published internationally in the fields of cosmetic dentistry, cosmetic dentistry and dental implants.

Smile Design and Ceramic Restoration in Esthetic Restorative and Implant Dentistry

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Language: English
Required: Computer with audio capabilities and high-speed internet access

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COMMITTED TO SIMPLY DOING MORE FOR DENTAL PROFESSIONALS
A simplified method for the removal of cemented implant prosthetics

Dr Scott Davis
Australia

There are times when it becomes necessary to remove the cemented prosthetic restoration from one or more implants and the prosthesis is not amenable to conventional crown and bridge removal devices. In order to remove these prostheses, we need to gain access to the abutment screws by drilling through the crown or bridge. The challenge is to create the smallest possible access holes.

This article will describe a simple method for constructing and using a device to guide the development of appropriate access holes in the implant prosthesis.

I was lucky enough not to have a patient with a loose or damaged bridge to use for this presentation, so I used a patient education model to provide the images to facilitate the description of the technique (Figs. 1a & b). Figure 2 shows the location of the implants.

Constrcuting the device

The master cast that was used for the construction of the implant prosthesis is the central element for this technique (Fig. 7). Long screws from impression copings (Fig. 4) or long laboratory screws are inserted into the implant analogues (Figs. 5a & b). The cast is blocked out with peryphery wax to act as formwork for the construction of the device (Figs. 6a-c). The wax should extend for at least one tooth on either side of the prosthesis.

If no tooth is present distally to the prosthesis, then additional teeth are covered anteriorly to maximise stability of the device. The wax should also block out the full dimensions of the prosthesis. I like to construct the mesial aspect of the device to be sufficiently wide and robust for a finger or thumb to be readily placed on this area for stabilising the device during preparation of the access holes.

The model and the screws are lubricated with either petrolatum or a water-based lubricant. Auto-polymerising or light-curing resin is adapted to the cast to cover the adjacent occlusal surfaces and encompass the screws in the implant analogues (Figs. 7a & b).

I prefer to use GC pattern resin and in the later stage of polymerisation, I remove the screws before they potentially become locked in the resin. Once the material sets, it is trimmed and polished (Figs. 8a & b) then checked for stability on the model. Additional material can be added if required.

If a stone model of the prosthesis is available, it is convenient to confirm the stability of the device and to assess that there is no contact between the prosthesis and the device (Fig. 9). The intaglio surface is adjusted as required to ensure appropriate adaptation.

In the clinic

The chairside process is simplified by the use of this acrylic resin guiding device that provides a visual aid for the appropriate position for drilling the access holes. Ideally, porcelain should be removed using a diamond high-speed bur with copious irrigation. I prefer to use a round diamond bur for this purpose, as it is less likely to cause porcelain chipping. If the prosthesis is metal ceramic, the metal substructure is first penetrated with a small round carbide bur. Subsequently, a metal-cutting tungsten carbide bur is used to widen the access as required. Figure 10 shows a screwdriver passing through the guide into the abutment screw. Figures 11a and b show the precision of the preparation without over-preparation.

Once the access hole has been debrided of obturating materials, an appropriate screwdriver is inserted. In order to prevent ceramic delamination, it is important to ensure the driver is not contacting any porcelain before significant torque is applied. I initially insert the driver and inspect for lack of contact with the porcelain. Following, I apply light hand torque to the driver in order to determine that it is fully seated before a second inspection to ensure no porcelain contact. Finally, the screw and the prosthesis are removed.

Discussion

Drilling free hand into the prosthesis with no guide can result in oversized access holes and wasted chairside time. The primary goal of the method described here is to maximise laboratory procedures in order to reduce chairside time. We also minimise the size of the access holes, which reduces the damage to the prosthesis.

Delegation of the construction of the device to a technical assistant can further reduce cost, for both the patient and us. Thereby, a task to which we look forward with trepidation can be reduced to a minor inconvenience.

By minimising the diameter of the access holes, we increase the probability that the prosthesis can be returned to the patient after dealing with the reason for removal. Once the prosthesis has been removed from the mouth, there are two options. Firstly, we could consider the abutment/prosthesis as a single item. After inspection and cleaning, the prosthesis can be replaced. Had the abutment screw become loose, then the grain structure of the screw may have become elongated and the screw should be replaced.

The second option is separating the abutment from the crown or bridge. When they cannot be separated by mechanical means, they can be separated by gentle heating in a furnace. Slowly heat to less than 200 °C for five minutes, then the abutment and prosthesis should separate very easily. Allow to cool to room temperature slowly, then inspect porcelain for defects before returning to the patient.

Contact Info

Dr Scott Davis works in a private prosthodontics practice in Port Macquarie in Australia. He can be contacted at scott@davisdental.com.au.
The 14th China Int’l Exhibition & Symposium on Dental Equipment, Technology & Products

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Discover the small world of ToothVille

LONDON, UK: Gummy bear attacks? Scuba-divers treating root canals? Decorators performing tooth-whitening sessions? Sound like an ordinary day at the dentist? Invite the miniature world of ToothVille into your waiting room and your ordinary day will be transformed—not forgetting meeting with the builders to discuss that cavity restoration.

Being a keen photographer, London-based dentist Dr Ian Davis has combined his two passions—dentistry and photography—to create ToothVille, a world of mouth moulds in which various dental treatments are carried out by miniature figurines. Inspired firstly by the artwork of Slinkachu (slinkachu.com) and the thought of what it would be like if teeth were large, Dr Davis has created a storm of creative inspiration for the dental world using the power of these little workmen. The ToothVille sculptures include decorators carefully whitening a set of teeth, scuba-divers carrying out root-canal treatments, emergency teams rescuing broken teeth and workmen guarding teeth from a sugar attack from three scary-looking Gummy Bears! ToothVille could be the perfect answer to the serious need to turn teeth and dentistry into accessible and approachable subjects for the public.

Patients at Dr Davis's surgery are experiencing a waiting room quite unlike any other; children and adults alike are being introduced to the unique world of ToothVille, describing the experience as anything from "amazing and funny" to "quirky". From laughing and giggling as they see the Gummy Bear attack, to cringing at the implant photographs, ToothVille "demystifies the treatment", teaching patients about cavity prevention and restoration in a way no other product has yet achieved.

Having placed pictures along corridors and throughout his waiting room, Dr Davis has also produced a book, mainly aimed at the younger generation, although adults also can't seem to put it down. The picture book, aiming to inspire prevention in all areas of tooth decay, begins with the least invasive treatments of cavity preparation and restoration and leads onto emergency dentistry, before embarking on photographs of miniature model scuba-divers recreating root-canal treatments. Whilst tiny workmen defend another set of teeth from sugar attacks, the book comes to an end with further photographs, carried out in pure ToothVille style, recreating the invasive treatment of an implant; the final destination that all teeth want to avoid.

Originally encouraged by his photography hobby, Dr Davis's passion for combining dentistry and photography is certainly becoming that of a business. Future models of ToothVille will see regular sugar attacks and further creations will be modelled on orthodontic treatment and tooth loss. Like existing ToothVille models, future photographs of the moulds will visually demonstrate different treatments, casting a brighter light on orthodontic treatments and expressing the manner in which tooth loss can be avoided, and in serious cases, repaired. Even though Dr Davis is focused on improving the models that he has already created, the "icing on the cake" would be to publish a children's book, providing the younger generation with a chance to learn about dental health in an entertaining and interesting way. With the miniature workmen as visual metaphorical representations of the "small things" in dental care, the models are fast becoming a useful way of conveying the message of maintaining good oral health.

Commenting on ToothVille, Dr Davis said, "ToothVille is quirky and makes the patients smile in the waiting room."
From the Editor’s Desk

Newsletter to him and his beloved

family for giving me this opportunity
to prepare my maiden Newsletter.

The response and contribution of articles
in the form of national dental

associations (NDA) has not been

encouraging. However, I view

this as my inexperience in present-
ing to them the nature of articles

I needed for this Newsletter. The

onus is on me to present an outline

and then followed by requesting

for the necessary information to

achieve this end. I would take this

as a learning curve and hopefully

I could be better in the coming issues.

it was once said, "The future is

here; it's just not widely distributed

yet.

My thoughts on the ADTA Study

Nearly two years ago, the Amer-

can Dental Trade Association

(ADTA) undertook a rigorous study
to bring about changes for an

timeless dental care. These changes

would reflect and retain its original objec-
tives of representing this vast Asia

region by focussing on upgrading the
dental education in this region.

Dr Oliver Hennedige

APDF Newsletter

a small organization with ambitious
trends for the dental industry. I thought
it would be helpful to share the highlights of the ADTA
with all of you. These high-

lights point to a considerable degree

of change—drastic in technology, changes in the marketplace,

and changes in the economic trends of
dental care. These changes would

have a considerable impact on the

subject topic of Continuing Profes-

sional Development (CPD).

From an economic context, the ADTA report suggests future
changes will move at a considerably
different pace. Today, more than

than in the previous 50 years! Movi-

ing a Fellowship will be awarded.

 edición is conducted by the College. On pass-

satisfied in attendance, knowledge

and motivation. This candidate must have

completed the required courses and pass

the examination conducted by the College to

be eligible to sit for an examination

organized dentistry through their

activities of APDF/APRO. Fellow-

ship based on dedication, moti-

vation and a personal commitment to serve

dentistry linked to APDF/APRO to serve

as the profession and the people in this

country for giving me this opportunity

and then followed by requesting

for the necessary information to

achieve this end. I would take this

as a learning curve and hopefully

I could be better in the coming issues.

(TJG, a 12-year member with current

knowledge and motivation. This candidate must have

completed the required courses and pass

the examination conducted by the College to

be eligible to sit for an examination

organized dentistry through their

activities of APDF/APRO. Fellow-

ship based on dedication, moti-

vation and a personal commitment to serve

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As the result of the World Congress, the

ADTA report predicts future changes will move at a consid-

erably different pace. Today, more than

than in the previous 50 years! Moving a Fellowship will

be awarded. The official meeting of dele-
gates in 1987 after several debates de-
cided on this double name—rather than changing it to just Asian Pacif-
ic Regional Organisation when it

joined the world body. It wanted to

reflect and retain its original objec-
tives of representing this vast Asia

Pacific region where two thirds of

humanity lived and at the same time

be a regional representative

sentative of the world. The

double name reflects its commit-
tment to the dental skills and respon-
sibilities of general dentists and specialists in the

various fields of dentistry. It aimed to

undertake this task by continuing
dental education programmes, spe-
cific courses and to bring continuing
dental education in every corner of

this vast region. It has the task of

upgrading practice and competency

of dentists and specialists.

To this end the College has con-
ducted joint scientific programmes in

member countries. Organised workshops and conferences are

offered by all the scientific programmes in

the Asia Pacific Dental Congresses for

1995 onwards. The College also

awards Fellowship based on dedi-
cated service to the profession and

organized dentistry through their

individual Associations or through activities of APDF/APRO. Fellow-

ship could be awarded by attend-

ing accredited courses and having

accomplished a certain number of

hours. Knowledge gained etc. the candidates become

eligible to sit for an examination

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fellowship will be awarded.

Today the Federation (APDF/

APRO) serves its member associ-
tions well and it is a truly useful um-
brilla organization of this region.

its annual congresses are leading
events in the region attracting both
the industry and delegates. The

College has continued to evolve

with a number of continuing dental

education programmes being con-
ducted in the region. It maintains

high standards in the scientific pro-

grammes of the Asia Pacific con-
gresses.

From a beginning of 52 dentists
from 8 countries today Asia Pacif-
ic Dental Federation/Asia Pacific

Regional Organisation and its

educational component ICODD

officially represents 27 countries

with annual congresses attracting

thousands of dentists each time it

is held. There are no such events

in countries’ invitations extend to

5 consecutive years ahead of time.

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Both the APDF/APRO and its

educational component ICODD

are well structured organisations.

They are truly the voice of dentistry

and dental health and continuing
dental education in this region.

APDF Newsletter

page

A brief history of the APDF

Dr T. S. Jeyalan

Editor

Dr How Kim Chuan

For that reason, the next quar-
ter century might best be described

as “transitional”. While the ADTA
report supports a positive future, it

also adds the qualifier that the

market must be willing to embrace

growth and change. Better policy

moves and focused leadership at
every level, in every sector, can

ensure a promise of effective, in-

novative dental-care services for

the entire population.

That said, I leave you with the

words of Mahatma Gandhi: “We

must become the change we want
to see.”
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