Dear reader,

Lately, I had the opportunity to visit two major gatherings of endodontists and implantologists in Europe. After listening to a number of lectures and speaking to experts it became obvious to me that both specialties are in almost total denial of one another.

This ongoing cease fire is nothing new to dentistry but it cannot disguise the fact that one field is slowly losing its grip, and the other is simply expanding. Tooth replacements have seen a remarkable upswing and are expected to gain a significant market volume of US$1 billion in the years to come. Growth rates have slowed down recently but this is due to the fact that more and more dental companies are jumping on the implant bandwagon and taking over market shares from big players like Nobel Biocare or Straumann. With the economy recovering in most parts of the world, people will also have more money in their pockets to invest in their smiles.

P-I Branemark’s call to let the patient decide at the Gothenburg Symposium last week must be acknowledged but it goes out to the wrong group of people. More and more patients want aesthetic teeth and they do not care about what it takes to get there. Latest studies also reveal that by now many consider aesthetics to be more important than function.

It is up to the dentists to decade whether a tooth should be replaced or not but constantly improving treatment options and lower investments will make the choice an easy one. On top of that, a growing number of implant vendors is practicing more aggressive marketing. It seems unlikely that many dentists will resist these market calls in the long-run.

In general practice, the key questions are whether the ulcers or lesions are recurrent or persistent, when they first occurred and the number, size and site of the ulcers. The answers to these five simple questions can render it easier to distinguish between ulcers in the mouth that indicate local disease and those that indicate systemic diseases. A medical history of course will often reveal that other sites are involved but sometimes mouth ulcers are the first signs of systemic diseases, particularly those of the gastrointestinal tract. If other oral signs are present, such as a depapillated tongue, this may indicate hematological deficiencies. The first decision is whether treatment is required at all or whether referral is needed; thus, the decision needs to be made from a picture alone and then decide which lesions may help to construct a treatment plan for the patient.

“Oral mucosal lesions—What GP’s need to know”

Since the mouth can reflect so many systemic diseases and can often be the first sign of such a systemic disease, then clearly general practitioners have a responsibility to be able to distinguish normal from abnormal mucosa and then decide which lesions may reflect oral disease and which may reflect systemic diseases. The key recommendation is then to include a thorough examination of the soft tissues when seeing dental patients.

 Yours sincerely,
Daniel Zimmermann
Group Editor
Dental Tribune International

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And the battle goes on...

Dear editor,

It sounds frightening to think that there are over forty different types of mouth ulcers. However, clinically they can be recognised as only four major presentations. If ulcers are recurrent, they are most likely to be of local origin.

What is known as recurrent aphthous stomatitis (RAS) ulcers linked to systemic diseases are usually persistent (present all the time) and are usually found in middle age onwards, although not invariably so. Single episodes of ulcers without persistent or recurrences are usually viral in origin; we regard a single persistent ulcer as being malignant until proved otherwise. Diagnosis of oral lesions is made by combination of the medical history and the clinical appearance, as well as any investigations.

In general practice, the key questions are whether the ulcers or lesions are recurrent or persistent, when they first occurred and the number, size and site of the ulcers. The answers to these five simple questions can render it easier to distinguish between ulcers in the mouth that indicate local disease and those that indicate systemic diseases. A medical history of course will often reveal that other sites are involved but sometimes mouth ulcers are the first signs of systemic diseases, particularly those of the gastrointestinal tract. If other oral signs are present, such as a depapillated tongue, this may indicate hematological deficiencies. The first decision is whether treatment is required at all or whether referral is needed; thus, the decision needs to be made from a picture alone and then make a decision as to whether referral is necessary. When a dentist suspects that a lesion may be malignant, then it is always best to refer the patient, since other investigations, such as a biopsy, and clinical examination, such as palpation of the lesion and local nodes, will assist the diagnosis. Speed is of the essence and a diagnosis cannot be made from a picture alone without these other factors.

Nevertheless, it is possible that there will be situations in which referral of the patient may be difficult, and in these situations the viewing of the image along with discussion with the practitioner may help to construct a treatment plan for the patient.

 Yours sincerely,
Daniel Zimmermann
Group Editor
Dental Tribune International

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Contact Info

Ajay Mahal

The rapid growth in the number of dental colleges, mostly private, over the last several years is a defining feature of dental education in India. On the other hand, however, shortages of teaching staff brought about by sharp increases in student strength, as well as a lack of quality of education imparted.

Efforts by the Dental Council of India (DCI) to enhance the quality of dental education in India and introduce stringent standards on the qualifications of dentists newly trained abroad are thus praiseworthy. These include making recognition of dental colleges conditional on making a fifth year of dental training compulsory. The latest rules also introduce a screening test for individual practitioners to attempt to test in dental health research and practice. The overall DCI approach of taking a long-term view of dental education in India is also encouraging.

DCI could direct more careful attention to two issues. The first has to do with perhaps the most visible members of the dental community—dentists. It is disappointing that compared to nearly 25,000 seats available for new entrants to dental colleges, there are only 1,700 slots for dental assistants and hygienists in India. This reflects a relative neglect of prevention in oral health and a lack of career opportunities for the latter. They are also likely to be taken up by diploma holders.

The second issue of concern is that compared to the number of dental colleges, there are only 1,700 slots for dental assistants and hygienists in India. This reflects a relative neglect of prevention in oral health and a lack of career opportunities for the latter. They are also likely to be taken up by diploma holders.

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