First Brånemark Symposium draws over 200 dental professionals to Sweden

GOTHENBURG, Sweden/LEIPZIG, Germany: Professor Per-Ingvar Brånemark from Sweden has urged dentist worldwide to refocus on their patients’ needs. Despite the recent developments in oral and maxillofacial reconstruction, the field should focus on the development of simple and affordable solutions rather than following commercial interests, he told Dental Tribune Asia Pacific during an exclusive interview at the first P-I Brånemark Symposium in Gothenburg last week.

80-year old Brånemark was the first clinician to place a modern dental implant back in 1965. He also discovered the concept of osseointegration, which had a huge impact on oral rehabilitation and other clinical disciplines such as orthopaedics.

The 3rd Brånemark Symposium, which is supported by dental heavyweight Nobel Biocare, is supposed to be the first in a number of interdisciplinary events focusing on issues like the quality of life, economics and ethics in regard to oral rehabilitation. The symposium drew over 250 international scientists and dental experts, among them doctors from Australia, China and India, to Gothenburg in order to meet and discuss the latest concepts and developments in oral and maxillofacial reconstruction including the latest advancements in implant surfaces, bone augmentation, as well as imaging and CAD/CAM-based prosthetics. New studies revealing promising satisfaction figures among patients that received treatment with dental implants were also presented.

“Osseointegration has been the major breakthrough in 20th century oral rehabilitation and brought together clinicians from different disciplines who otherwise may not have met,” said Dr Daniel van Steenberghe, Belgium, Scientific Chairman of the Symposium. “The purpose of this meeting is to enhance this cooperation for the sake of the patient.”

According to latest industry figures, the worldwide market volume for dental implants was US$790 million in 2006. Industry experts say that this volume is expected to increase further due to lower delivery costs and better long-term clinical results.

Medical tourism slows down, but could recover

While the economic recession has eroded the growth rate for medical and dental tourism by approximately 15.6 per cent from 2007 to 2009, the economic recovery may help spur a sustainable 55 per cent annual growth rate for the medical tourism industry by 2010, according to a new report released by the Deloitte Center for Health Solutions in the US.

Medical tourism has experienced a significant slow down driven by consumers putting off elective medical procedures over the past two years. However, a better economy and health care reform in the US will likely propel growth in the elective outpatient market, particularly if elective cosmetic and dental procedures are not considered basic benefits, the report states. In 2008, a projected number of 648,000 Americans will travel abroad for outbound medical and dental care.

China rivals US in research race

A new report by Thomson Reuters has found that Chinese researchers have more than doubled their output of scientific papers in recent years and now rank second after the United States in terms of volume. In 2008, China published 112,000 papers compared to 540,000 in the US.

Patients in danger of zinc overdose

The US Consumer Healthcare Products Association has recently issued a national alert against the use of denture creams containing zinc. According to the organisation, exposure to excess zinc through those creams can lead to unexplained weakness, loss of sensation or other nerve symptoms.

Alkalines can damage teeth too

A new study from the Sahlgrenska Academy in Sweden has revealed that substances with high pH values damage enamel, a condition usually associated with acid erosion. The researchers exposed extracted teeth to a number of alkaline substances such as household degreasers and found that organic material on the surface of the tooth dissolves rapidly indicating that the organic components of the enamel are also affected, as the enamel becomes more porous.

Alkaline degreasers are mainly used in the food industry, among other things to clean professional kitchens, but are also common in the automotive care industry and to remove paint from walls and other surfaces.

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We shape the future of dentistry with our innovative products and systems. They distinguish us in the field of restoratives, all-oroceas and aesthetic prosthetic solutions. A wealth of experience, great commitment and innovative ideas help us to always find the optimum solution for high-quality products that allow you to make people smile.

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The search for an effective utilisation formula

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Tissue engineering is based on the concept that the human body or parts of it can be regenerated using stem cells. Since the 1980s, several kinds of tissues and organs have been generated worldwide using cultured living cells. Dental Tribune Asia Pacific in cooperation with FDI’s World Dental Federation spoke with Dr Minoru Ueda from Nagoya University in Japan about key tissue-engineering strategies and their potential for dentistry.

DTW/DU: Dr Ueda, tissue engineering is a relatively new approach in regenerative medicine. How did it find its way into dentistry?

Dr Minoru Ueda: The basic concepts and strategies for tissue regeneration are very old. To regenerate any tissue, we need stem cells, growth factors and a scaffold. In the field of dentistry, we have made much scientific progress in terms of materials, which gives us an advantage over other fields of medicine. We began with developing high-quality materials and then expanded to using stem cells.

What key tissue-engineering strategies are currently being developed for dentistry and how do they work?

The most important tissue for dentistry is bone. We are establishing technologies for bone tissue engineering and apply these clinically to implant surgery. Secondly, we are focusing on stem cell science. Oral tissue contains a kind of powerful stem cell that can be used to treat systemic diseases, such as brain infarction or heart infarction. The dental pulp stem cell is one of the most important cells derived from oral tissue.

Is it possible to reconstruct complex tissue defects made up of multiple tissue types?

Yes, it is. We have succeeded in reconstructing the structures that make up periodontal tissues, which are cementum, bone and periodontal ligament in humans.

There is different legislation around the world regarding stem cell research. Could you please explain how the situation in Japan differs from other parts of the world and its effect on your research?

We do basic research using animal cells and human stem cells, but research using embryonic stem cells (ES) and induced pluripotent stem cells (iPS) must be performed under the control of ethical committees of each university. In order to use ES or iPS, we need special permission from our university and government. Clinical studies based on basic research also require approval from our university and government. It is actually very difficult to gain approval compared to other countries. So it is easy to conduct basic research but very difficult to conduct clinical studies in Japan.

What effect will tissue engineering have on the dental practice during the next 20 to 25 years?

Tissue engineering could provide a new treatment method for diseases that have not been treatable thus far, such as severe periodontal disease and atrophied alveolar ridges. Also, cosmetic therapy using tissue engineering in the oral and maxillofacial regions will become possible.

Atrophied alveolar bone and severe periodontitis.

Which dental conditions will be the first to be treated or cured by tissue engineering?

Atrophied alveolar bone and severe periodontitis.

Alternative alveolar bone and severe periodontitis.

What is the future of maxillofacial regions?

Maxillofacial areas, especially into the face because cosmetic problems such as wrinkles are not a disadvantage. The surface structures of an implant are very important, but this is not a main factor for enhancing the living cell around the fixture.

What is your opinion on the matter?

Dentists should not be allowed to inject any cells by themselves for non-dental reasons. However, for cosmetic reasons, dentists can inject stem cells into the oral and maxillofacial areas, especially into the face because cosmetic problems such as wrinkles are not a disadvantage. The surface structures of an implant are very important, but this is not a main factor for enhancing the living cell around the fixture.

What will be the first to be treated or cured by tissue engineering?

Atrophied alveolar bone and severe periodontitis.

Tooth loss.

Tooth replacement.

Tooth regeneration.

Is it possible to reconstruct complex tissue defects made up of multiple tissue types?

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India plans to overhaul dental education system

Daniel Zimmermann
DIT

HONG KONG/LEIPZIG, Germany: The Dental Council of India has recently announced the introduction of changes to the country’s deficient dental education system. According to Council President Dr Anil Kohli, who spoke to dental graduates of the Sri Ramakrishna Dental College and Hospital in Coimbatore in September, the Council will be investigating the accreditation standards for graduate and postgraduate dental courses, as well as continuing dental education and clinical fellowship programmes. Other issues such as CE recognition in India and abroad will also be reviewed.

India has the largest number of dental schools and students in the world but the quality of dental education has deteriorated recently, especially in economically under-developed areas. In addition, many graduates are forced to quit dentistry owing to limited career options.

Dr Kohli said that the implementation of the changes will take several years to complete and that they are needed to improve the quality of dentistry in the country and to attract more students from foreign countries. He also stressed the need for a national oral-health policy.

“Our own figures show that only four to five per cent of the population visit a dentist. We’ll have to look at this aspect as the next frontier of dental care in India if we are going to provide fruitful employment to our fresh graduates,” he added.

Implant group in AP goes online

Daniel Zimmermann
DIT

HONG KONG/LEIPZIG, Germany: The International Congress of Oral Implantologists (ICOI) has recently launched a new website for its members in the Asia Pacific region. The site, which offers services in English, Japanese and Chinese, is supposed to help Asian members of the ICOI to communicate with their respective offices in Shenzhen and Hong Kong, as well as to complete memberships, Fellowship, Masterships and Diplomate applications in their native language, the organisation has announced in a press release.

The ICOI currently has component societies in Korea and China and affiliate societies in Australia, Hong Kong, Taiwan, Singapore, India, Thailand, Japan and the Philippines. Approximately 2,000 implant specialists from Asia are members of the ICOI.

The organisation has also announced a new partnership with the Chinese Stomatological Association to provide better dental and implant education to dental professionals in China. Expected to be finalised at the American Lifestyles Expo in Hangzhou later this month, the initiative titled “Smile and Chewing Technology” was created to promote how dental care and implant technology could improve the quality of life of Chinese people, according to ICOI officials. It will be supported by industry giants like Johnson & Johnson, Nobel Biocare and Yoshida Dental.

Founded in 1972, the ICOI is one of the world’s largest organisations for dental implantology. It also provides continuing dental implant education through a number of symposiums and workshops. The organisation also publishes Implant Dentistry, a publication designed to keep members abreast of the latest research and clinical concepts as well as numerous ICOI activities and those of their component and affiliate societies.
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 it’s not implantology. 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 Bränemark’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 decide whether a tooth should be replaced or not but constantly improving treatment options and lower investments will make the choice an easy one. Group therapy is growing and offers a better alternative to individual therapy. It seems unlikely that many dentists will resist these market calls in the long run.

In Gothenburg, a clinical scan was shown where basically all teeth had been replaced with implants. As ridiculous as this example may be, it does hold true. Don’t look very bright for the ‘root’. 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, as only four major presentations.

What GP’s need to know

It is observed that over 40% of patients present with a single ulcer and the local disease and those that indicate systemic diseases. A medical history of the patient 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 oral ulcer 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 make a decision based on the severity of the problem. A general rule is that if the dentist feels that the ulcers reflect systemic diseases, then they should all be referred for further investigation. The majority of cases of RAS can be treated in practice and it is perfectly acceptable for practitioners to attempt therapy and then to refer should this therapy not be successful.

Oral mucosal lesions—What GP’s need to know

Since the mouth can reflect so many systemic diseases and can 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 oral examination of the soft tissues when seeing dental patients.

And the battle goes on ...

Dental education in India

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 one hand, this development can be considered beneficial as it potentially helps address a severe shortage of dental personnel in India. On the other hand, however, shortages of teaching staff brought about by sharp increases in student strength, together with issues on the quality of education imparted.

Efforts by the Dental Council of India (DCI) to enhance the quality of dental education in India and implementing stringent standards on the qualifications of dentists newly trained abroad are thus praiseworthy. These include making recognition of dental colleges conditional on making a 5th year of dental education compulsory. The latest rules also introduce a screening test for individual practitioners to enable the council to enhance the supply of teaching faculty. DCI promotion of Continuing Medical Education programmes can help enhance the quality of dental care providers and exposing teaching faculty to the latest 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 training of dental hygienists and dental chair assistants. 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 less willing to work in remote districts. The second issue of concern is that of implementation of DCI guidelines. This is not a view held only by well-articulated regulations and poor follow up. It would be useful to think about effective monitoring mechanisms and evaluation of some of these promising initiatives that DCI is embarking on.
AEE: Issue in implant debate comes down to saving teeth

CHICAGO, IL, USA: The American Association of Endodontists (AEE) has expressed serious concerns over recent assertions by the American Academy of Implant Dentistry (AAID). According to the endodontist group, the implantologist group’s position reinforces outdated myths about root canal treatment.

A press release distributed by the AAID on 21 September positioned implants as a better option than root canal treatment for a variety of reasons, including higher success rates and lower financial burdens—claims that root canal specialists say are inaccurate and misleading to potential patients.

“Not only has it been proven that both treatments have the same success rates,” said Dr Gerald N. Glickman, president of the AAE, “but several studies show that root-canal treated teeth are retained at about 95 to 97 per cent after eight years, versus implant retention of 85 to 90 per cent during a similar time period. The AAID chose to ignore the scientific literature in its news release.”

Dr Glickman also noted the inference that diseased teeth are not worth saving, which he said does a disservice to both patients and the dental profession as a whole.

“Do patients with a broken arm expect their doctor to give them a prosthetic arm?” he asked. “Why would the same patients believe they need to get a prosthetic tooth screwed into their jaw if the real tooth could be healed?”

Saving teeth is not so much a matter of ‘dental heroics’ as it is serving the best interests of the patient, and root canal specialists proudly do so in a manner that is consistent with the American Dental Association’s Principles of Ethics and Code of Professional Conduct.

“And arguments that root canal treatment is more costly are fatuous,” Dr Glickman added. “Recent research has proven that saving the natural tooth with a root canal rarely requires follow-up treatment and generally lasts a lifetime; implants, on the other hand, have more post-operative complications, and therefore would probably present the more significant financial burden.”

Dr Glickman recognises that there are cases when a tooth cannot be saved, for which implants would be a realistic option. He pointed out that root canal specialists are ideally qualified to make such a determination with a patient’s general dentist, and that all dental professionals are ethically obligated to inform patients of all available treatment options. “This whole paradigm is ultimately not about which treatment modality is better, but what is best for each patient. And that is the preservation of the natural dentition,” he said.
Leipzig, Germany: Straumann’s dental implant alloy Roxolid is now available to dentists in Europe. Following the recent launch in North America, the material was introduced at the 18th Annual Meeting of the European Association for Osseointegration (EAO) in Monaco. Roxolid combines high tensile and fatigue strengths with excellent osseo-integration, according to the latest clinical research. It is designed to increase reliability and confidence, especially with small diameter implants.

Involving 60 centres and more than 500 patients, Roxolid has been tested in one of the largest clinical research programmes ever undertaken by a dental implant company in recent years. Currently, two other large multi-centre clinical trials are in progress.

Company officials announced that the clinical programme has been extended to include studies specifically investigating the need for bone augmentation and the performance of Roxolid in the front of the mouth and in narrow spaces. In addition, preclinical testing has been broadened to investigate healing characteristics and to draw direct comparisons with other titanium alloys.

Roxolid is available in 03.5 mm Bone and Soft Tissue Level implants.
Claims of mercury to cause autism rejected
New study finds similar levels in autistic and normal kids

WASHINGTON, DC, USA: Children with autism have mercury levels similar to those of other kids, suggesting the mysterious disorder is caused by a range of factors rather than “a single smoking gun,” researchers at the University of California, Davis, said. They found that children aged 2 to 5 with autism had mercury levels lower than other children because the autistic kids ate less fish, the biggest source of mercury that shows up in the blood. But when the data were adjusted for lower fish consumption, blood-mercury concentrations among the autistic children were roughly similar to those developing typically. The children with autism had mercury levels in line with national norms.

The findings, published online in the journal Environmental Health Perspectives, come at a time when advocates including parents argue that mercury found in fish, dental fillings, vaccines and industrial emissions are responsible for autism. The debate became more vehement recently after the US Centers for Disease Control and Prevention said autism was more common than previously thought, affecting one in 58 kids.

“It’s time to abandon the idea that a single smoking gun will emerge to explain why so many children are developing autism,” said Irva Hertz-Picciotto, who led the study. “Just as autism is complex, with great variation in severity and presentation, it is highly likely that its causes will be found to be equally complex,” she said in a statement.

Autism refers to a spectrum of diseases, from severe and profound inability to communicate and mental retardation to relatively mild symptoms. The research area is due for a large infusion of money from President Barack Obama’s US$5 billion plan to boost US medical and scientific research.

Activists noted that the University of California study did not seek to find out whether mercury might cause autism because the children’s blood levels were measured after autism had been diagnosed.

“The results of this study are limited in terms of ruling in or out a link between mercury exposure and autism causation or severity,” said Sallie Bernard, executive director of the advocacy group SafeMinds.

Vaccines with mercury-containing preservatives such as thimerosal have also been blamed by some parents as a potential cause of autism, although many studies and several reports from the Institute of Medicine have found no link.

University of California Davis researchers looked at 452 children, including 249 with autism, 60 who had other developmental problems including Down’s syndrome and 145 children without disorders.

They also examined a variety of mercury sources including fish, nasal sprays, earwax removal products, vaccinations and dental fillings made from a mercury-based amalgam.

Autism researchers are looking at a broad range of environmental factors including household products, medical treatments, diet, food supplements and infections. Other recent studies have found strong evidence that there are several genetic causes for developing autism.

“Claims of mercury to cause autism rejected”

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“The evidence to date suggests that, without taking account of both genetic susceptibility and environmental factors, the story will remain incomplete,” Hertz-Picciotto said. “Few studies, however, are taking this kind of multifaceted approach.”

(Edited by Daniel Zimmermann, DTI)
New York meeting to showcase innovative programmes

Fred Michmershuizen

NEW YORK, NY, USA: As hosts of the largest dental meeting in the USA, the organisers of the Greater New York Dental Meeting (GNYDM) feel they have an obligation to the exhibitors and attendees to excel in presenting a convention that showcases the latest products, procedures and technologies modern dentistry has to offer. To this end, the 2009 GNYDM, to be held from 27 November to 2 December, will feature a wide array of new programmes.

In 2008, some 57,854 attendees from 125 countries participated. Pre-registration for 2009 suggests that the number of attendees this year will be even higher.

Dental technology is advancing at an astounding rate. Thus, the Pride Institute and the GNYDM are partnering for the first Technology Fair that will run for four days and take place on the newly expanded exhibition floor. On 29 and 30 November, the Pride Institute an annual fair that is customised to the specific needs of the rapidly expanding technology sector,” said Executive Director of the GNYDM Dr Robert Edworthy. “We think it will be a great time saving for attendees to have all the technology, education and materials in one place.”

Additionally, the GNYDM will again partner with Algo Technology to hold its second educational event Invisalign-GNYDM Expo, which will offer numerous programmes that will help dental teams learn the logistics of tooth alignment with Invisalign from some of the finest clinicians in the world.

As Invisalign has grown so rapidly in popularity, the 2009 meeting will feature four days of Invisalign programmes for the entire dental team. With such a diverse range of educational Invisalign programmes offered, there is something for everyone on the team.

All courses will be taught by Invisalign experts and will take place in the Invisalign Pavilion on the exhibition floor. “In 2008, the Invisalign event attracted more than 1,200 registrants, and we are expecting even greater participation this year,” said GNYDM General Chairperson Dr Clifford Salm.

The GNYDM, one of the largest and most prestigious dental congresses in the USA, is a joint venture of the New York County Dental Society and the Second District Dental Society located in Brooklyn and Staten Island. GNYDM provides a broad range of educational programmes and hosts over 40,000 health-care professionals annually.

ESCD places focus on patients

Claudia Salwiczek

PARIS, France/LEIPZIG, Germany: Members and friends of the European Society of Cosmetic Dentistry (ESCD) meet in Paris for their 6th annual meeting. Two hundred attendees from Denmark, Croatia, Serbia, Germany, Hungary, and even as far as Australia travelled to the French capital to learn about the newest techniques and products, to mingle with colleagues and to enjoy some of the countless Parisian attractions.

“Dental technology has always been an important part of our meeting, so we are very excited to jointly host with the Pride Institute an annual fair that is customised to the specific needs of the rapidly expanding technology sector,” said ESCD President Dr Wolfgang Richter and Congress Chairperson Dr Jean-Paul Djian.

The noteworthy line-up included 20 international speakers from India, the UK, Germany, Austria, the USA, and, of course, France. Over the course of two days, scientific sessions and workshops enlightened participants on diverse topics, such as predictable bite registration, modern concepts and risk factors in aesthetic dentistry, aesthetic dilemmas and solutions, the use of composites, anterior restorations, and the therapeutic advantages of chairside CAD/CAM.

Minimally invasive dentistry and an interdisciplinary approach to aesthetic dentistry were the focus of most lectures. For instance, Dr George Kirtley (USA), the creator of the Envision A Smile cosmetic imaging system, highlighted the importance of an interdisciplinary approach and reminded the audience that “we treat patients, not just teeth!” Blondines, aesthetic improvements are the collaborative effort of many different specialists, such as orthodontists, endodontists and periodontists, and in some cases also psychologists and nutritionists, he added.

With an impressive case demonstrating total facial aesthetics, which was certainly enlightening for attendees, Dr Kurt Vinzenz (Austria) opened investigators’ eyes to what is possible beyond aesthetic dentistry. Sasha Jovanovic (USA) and Dr Bernard Touati (France) concluded the meeting with their respective lectures via live web conference from Los Angeles.

ESCD President Dr Wolfgang Richter concluded the meeting on a positive note: “We are very pleased with the meeting, especially considering the difficult economic times, and look forward to seeing everyone again in 2010,” Dr Richter told Dental Tribune.

Next year’s meeting, which will be held in conjunction with the AACD, will take place in London from 25 to 27 September.
ALPRO drives safe and clean infection control

Daniel Zimmermann

DTI

LEIPZIG, Germany: Germany-based ALPRO is offering a range of new and proven products for treatment-water disinfection and the removal of biofilm from the dental industry is looking to capitalize on this. In a slowing economy, the need for manufacturers and suppliers to both increase awareness of their products and transact business is pertinent. In a slowing economy, IDEM Singapore 2010 offers an excellent opportunity for manufacturers from around the world to meet and conduct trade in a central location in the Asian region. Since the meeting’s inception, we have continued to evolve IDEM to suit the needs of the dental industry in the region. IDEM Singapore will benefit from the extensive knowledge and experience we have garnered from the previous five IDEM events and our global expertise and resources as an organiser and manager of conferences and exhibitions.

Dr Lee, what issues did SDA consider in devising the conference theme for IDEM Singapore 2010?

Dr Lewis Lee: The rapid growth in popularity of and new developments in dental implants and related products, materials and techniques have dominated the dental landscape around the world for some time. In planning the scientific conference for IDEM Singapore 2010, we sought to address the increasing needs of the dental community for comprehensive information on the latest developments in these areas.

What will conference delegates gain from this scientific conference?

We have organised a multifaceted programme led by international presenters that will give delegates access to the latest research and developments in the fields of dental aesthetics and implantology, as well as practical advice on treatment planning, operative techniques and post-operative care. We believe delegates will leave the conference with knowledge that can be incorporated into daily clinical practice and a greater understanding of key principles and philosophies at the leading edge of dentistry today.

Thank you very much for the interview.

(This interview is published with permission from the FDI World Dental Federation.)
It is an undisputed fact that in the world of dentistry, no amount of expensive advertising or fancy marketing can beat the power of word-of-mouth referrals from your satisfied patients. What your patients say about you is the ultimate driver of your business success. Today, consumers turn to the Internet to locate and select a dental practice. Understanding this and using the right tools will help you create and maintain the most relevant, valuable practice builder you’ll ever have: the experience and feedback of your own patients shared with millions of prospective patients actively seeking a new dental practice. It’s up to you to choose: will your online reputation consist of a single thread of random gossip, or will it be become your most valued asset, carefully managed and nurtured to give you the best return on your investment?

Every known consumer will share a good experience with a few people, but they’ll make a point of telling the world about a negative one. As a service provider, you and your staff are your most valuable tools. You don’t sell widgets; you sell your skills, experience, specialties, personalities, hours and location—and your very existence and livelihood depend on your reputation.

We all work hard to ensure our patients have a good experience and ask that you refer friends and family based on this. Now, take that a step further, expand it to hundreds or thousands of prospective patients, and you’ve just moved from the world of offline word-of-mouth referrals to the sophisticated new world of online reputation-based marketing—or word-of-mouth 2.0.

We know that in the growing world of online reviews, consumers want and expect to find the local user information they seek, whether it’s a great Italian restaurant or top-notch cosmetic dental practice. As the Internet has come of age, new opportunities for valuable goods and services have exploded. The advent of local reviews provides a return to neighbourhood intimacy—and neighbourhood reputation.

It is highly likely you already have an online reputation, and may not even know it. Through online web sites, consumers can review and rate your business. There is no way to know whether their comments are legitimate. In fact, these people you’ve never seen your dental chair. Like it or not, these consumers are establishing your online reputation—without your knowledge.

However, even the world’s leading search engine recognizes the extreme power and relevance of word-of-mouth feedback. Google recently expanded its offerings to enable consumers to search for and compare local businesses online. Try searching for a dentist in your area by typing in your postcode followed by the word ‘dentist’ in the Google search box. A map with a listing of relevant, valuable practice information will result in one or two reviews posted over the course of several months.

The proactive approach: today, the only integrated approach to proactively managing your online reputation on Google is through companies such as Demandforce (http://demandforce.com/), an online patient-communication company. They recently announced a data integration agreement with Google that enables dental practices to populate their Google profiles easily, including posting reviews directly from data originating from their communication systems.

With Demandforce, each patient is automatically sent a thank-you e-mail message after each appointment. As part of the thank-you, they can choose to submit a confidential survey of their visit, as well as a public review. You can read the reviews of your practice and post a response or ask for a review to be removed if it does not meet standard posting requirements. After seven days, the data is automatically sent to Google to populate your profile.

Sought or not, online reviews are here to stay. Your patients’ satisfaction and their resulting word-of-mouth referrals will always be your best prospect, and you can use your online reputation knowledge to transform your practice. Your online reputation is your business and those practices that realise this early on will have a significant head start over their peers.

How leveraging one’s online reputation can help attract new patients

It is highly likely you already have an online reputation, and may not even know it

People will share a good experience with a few people, but they’ll make a point of telling the world about a negative one. As a service provider, you and your staff are your most valuable tools. You don’t sell widgets; you sell your skills, experience, specialties, personalities, hours and location—and your very existence and livelihood depend on your reputation.

We all work hard to ensure our patients have a good experience and ask that you refer friends and family based on this. Now, take that a step further, expand it to hundreds or thousands of prospective patients, and you’ve just moved from the world of offline word-of-mouth referrals to the sophisticated new world of online reputation-based marketing—or word-of-mouth 2.0.

We know that in the growing world of online reviews, consumers want and expect to find the local user information they seek, whether it’s a great Italian restaurant or top-notch cosmetic dental practice. As the Internet has come of age, new opportunities for valuable goods and services have exploded. The advent of local reviews provides a return to neighbourhood intimacy—and neighbourhood reputation.
Diagnosis and management of dentine hypersensitivity

Dr David G. Gillam
UK

The aim of this review is to update dental professionals on this troublesome clinical condition that is not fully appreciated by many dental practitioners and as such is often under-diagnosed in dental practice.

Diagnosis and differential diagnosis

Before considering a treatment strategy for the management of the condition, it is important to note from the published literature that there are a number of individuals who may be at risk from dentine hypersensitivity (DH), for example overenthusiastic brushers, periodontally treated patients, bullimics, people with xerostomia, high-acid food/drink consumers, older people exhibiting gingival recession, and people who chew ‘smokeless’ or ‘snuff’ tobacco.

History-taking, oral examination and diagnosis

One of the difficulties facing the dental professional when confronted with a patient complaining of tooth pain is that there are a number of clinical conditions that may elicit the same clinical symptoms as DH, and they have to be eliminated before a correct diagnosis of DH can be made. It is also important to acknowledge that patients who have been suffering from various types of orofacial pain in the form of toothache or tooth sensitivity may suffer various physical or emotional symptoms that can be very upsetting and disturbing to them. For example, they may experience a feeling of despair or helplessness, and frustration of not being able to cope and relying on a dental professional to resolve their problem. This in turn may make recording a satisfactory history of the condition difficult and the dental professional will need all his or her skills in obtaining the correct diagnosis, which will lead to a successful conclusion in his or her treatment strategy. In a busy dental practice, this may take time and the dental professional needs to be a good listener, sympathetic and patient in order to elicit the necessary information from the patient. However, it is important to remember that no irreversible treatment procedure should be performed until a definite diagnosis is made; in other words, no diagnosis, no treatment.

No doubt dental professionals may remember various acronyms from Dental School such as ‘LOCATE’ and ‘SOCRATES’ in order to aid them in obtaining sufficient information about the character, site, onset, duration, periodicity and severity of the problem that the patient may have when they come to see the dental professional (the reason for attending). Further questions as to what makes the problem better or worse, as well as asking the patient to describe the pain he or she is experiencing using word descriptors such as in the McGill Pain Questionnaire may also be useful) may give the dental professional more information to aid his or her search for the correct diagnosis. A useful question in relation to the severity of the pain is asking the patient to estimate his or her pain on a 0 to 10 visual analogue scale (no pain to very severe pain) or simply relate it as a 0 to 10 numerical score. It is important for the dental professional to conduct this part of the diagnostic process in a systematic manner. Once the history-taking has been completed the patient should be examined, in order to diagnose the presenting problem that patient may have. This will include all extra-oral and intra-oral tissues (including palpation) in a thorough and systematic manner. Various investigational aids, such as radiographs and vitality tests, relevant to the oral examination may be taken and these should be able to confirm the clinical diagnosis based on a thorough history. Identification of localised areas of exposed buccal or facial aspects of dentine may be investigated by using an explorer probe and gently drawing it across the dentine surface. This procedure may elicit a response from the patient, although it is generally accepted that a blust of cold air from a dental air syringe is more likely to record a response from the patient if his or her problem is due to DH. A practical tip the dental professional can use in the diagnostic process is to apply a varnish such as Duraphat on the affected area and then retest using a cold air blast. If the patient’s response indicates a reduction in his or her discomfort this may indicate that the problem is due to DH. This however should not exclude the dental professional from identifying and relieving any aetiological and predisposing factors in his or her management strategy.

It is important to note that diagnosis may not be simple, as there are a number of conditions that may cause similar symptoms, of which the dental professional needs to be aware. These may include conditions such as cracked tooth syndrome, dental caries, reversible and irreversible pulpotis, fractured teeth or restorations, post-operative sensitivity (from restorative, periodontal and bleaching procedures) and atypical facial pain (see also Table 1, page 12). These may well require a prolonged clinical examination using various diagnostic tests (such as vitality pulp tester, ethyl chloride, ice stick, percussion, and radiographs). A useful tip in diagnosing cracked tooth syndrome, for example, is the use of a diagnostic local infiltration (DTI/Photo Tjerrie Smit).

The importance of the definition as suggested by Addy et al. and evident from the Canadian consensus document is that it provides a very useful clinical description of the condition and suggests the need to exclude other forms of tooth pain or sensitivity.

Counselling and prevention

This aspect of the diagnostic and management process is

Trends & Applications

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Counselling and prevention

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AD

DH by providing a toothpaste, often forgotten. It is not accept-

Table 1: Differential diagnosis of dental pain (adapted from Aghababa) :

<table>
<thead>
<tr>
<th>Aetiology</th>
<th>Pain character and timing</th>
<th>Pain intensity</th>
<th>Provoking factors</th>
<th>Believing factors</th>
<th>Associated features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentine hypersensitivity</td>
<td>Sharp, stabbings, stimulation evoked</td>
<td>Mild to moderate</td>
<td>Thermal, evaporative, tactile, chemical, osmotic</td>
<td>Removal of the stimulus</td>
<td>Attrition, erosion, abrasion, abfraction</td>
</tr>
<tr>
<td>Reversible pulptis</td>
<td>Sharp, stimulation evoked</td>
<td>Mild to moderate</td>
<td>Hot, cold, sweet</td>
<td>Removal of the stimulus</td>
<td>Caries, restorations</td>
</tr>
<tr>
<td>Irreversible pulptis</td>
<td>Sharp, throbbing, intermittent/continuous</td>
<td>Severe</td>
<td>Hot, chewing, biting</td>
<td>Cold in the late stages</td>
<td>Deep caries</td>
</tr>
<tr>
<td>Cracked tooth syndrome</td>
<td>Sharp, intermittent</td>
<td>Moderate to severe</td>
<td>Biting, ‘rebound pain’</td>
<td>Trauma, para-functional</td>
<td></td>
</tr>
<tr>
<td>Peri-apical periodontitis</td>
<td>Deep, continuous boring</td>
<td>Moderate to severe</td>
<td>Biting</td>
<td>Removal of trauma</td>
<td>Peri-apical redness, swelling, mobility</td>
</tr>
<tr>
<td>Lateral periodontal abscess</td>
<td>Deep, continuous aching</td>
<td>Moderate to severe</td>
<td>Biting</td>
<td>Deep pockets redness and swelling</td>
<td></td>
</tr>
<tr>
<td>Peri-coronitis</td>
<td>Continuous</td>
<td>Moderate to severe</td>
<td>Biting</td>
<td>Removal of trauma</td>
<td>Fever, malaise, imprint of upper tooth</td>
</tr>
<tr>
<td>Dry socket</td>
<td>(acute alveolar osteitis)</td>
<td>Continuous</td>
<td>4–5 days post-extraction</td>
<td>Moderate to severe</td>
<td>Irrigation, Loss of clot, exposed bone</td>
</tr>
</tbody>
</table>

Management of dentine hypersensitivity

It is important that the den-

Management should be based on the severity of the condition. For example, for

The importance of counselling the patient concerning his or her intake (especially fre-

The dental professional can be instrumental in educating the patient by providing informa-

The early history sheets to help both the patient and the dental pro-

It is important that the den-

The dental professional may continue with

Pain relief

No pain relief

No treatment required | Differential diagnosis of DH

Yes | DH not confirmed

No | DH confirmed

Treat with consideration for convenience and cost-

Confirm diagnosis of DH

Treat with consideration for convenience and cost-

Yes | DH not confirmed

No | DH confirmed

continue to review.

Reinforce preventive advice;

There is a very strong placebo effect present when assessing pa-

Note 5: If mild dentine hypersensitivity persists after the initial follow-up appointment, the dental professional may continue with

Note 4: If acute pain is present, further diagnostic procedures (e.g. desensitizing dentifrice)

Note 3: Pain associated with the tooth being removed (by demonstration, professional literature etc.) on cor-

Note 2: Alternative causes of tooth pain include: caries, chipped teeth, cracked tooth syndrome, fractured or leaking restora-

Note 1: Pain evoked by thermal, evaporative (jet of air), probe, osmotic or chemical stimuli as part of the clinical exam-

Fig. 1: Flowchart for the clinical management of dentine hypersensitivity (adapted with permission of George Warman Publishing Ltd.)

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Note 6: Pain associated with the tooth being removed (by demonstration, professional literature etc.) on cor-

Note 7: Identifying dentine hypersensitivity prior to the initial follow-up appointment, the dental professional may continue with

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“Most people are worried it is often something worse.”

Dr Nick Rote. East Finchley, UK

1 in 3 people suffer from dentine hypersensitivity and over 50% of sufferers don’t mention it to their dental professional.¹ Research shows that this may be because they fear it requires major dental work, the pain may be variable so they don’t report it or because they may be using techniques to try and avoid the pain.²

These findings highlight the important role that dental professionals play in actively diagnosing dentine hypersensitivity.

Recommending daily brushing with Sensodyne is a simple, effective solution which is clinically proven to reduce the symptoms of dentine hypersensitivity.

“When they come back to see me next time, they’re very pleased that the solution was given to them so easily.”

² Canadian Advisory Board on Dentine Hypersensitivity. Consensus-Based Recommendations for the Diagnosis and Management of Dentine Hypersensitivity, J Can Dent Assoc 2003; 69(4): 221-226

*Sensodyne is a registered trade mark of the GlaxoSmithKline group of companies. Further information is available on request.

DAILY PROTECTION FROM THE SYMPTOMS OF SENSITIVE TEETH
one to three months; 8 al-
this condition.
as an acceptable treatment for
be undertaken before this
prudent for more research to
be recognised in this article, providing
these studies are somewhat equivocal; therefore, it may be prudent for more research to
be undertaken before this technique can be recognised as an acceptable treatment for this condition.

Guided tissue regeneration and flap procedures to treat DH associated with localized gingival recession have also been recommended. However, these should not necessarily be the first treatment option for resolv-
ing the problem and, as indicated in this article, providing a treatment procedure without identifying and modifying the pathological and predisposing features responsible may not resolve the problem in the long term. Post-operative pain follow-
ing periodontal procedures such as scaling, root surface debridement and periodontal surgery may also be problem-
atic in the short term and palliative procedures, such as the application of varnishes (for example, Duraphat), resins etc., as well as the adjunctive use of a desensitising mouth
wash, may also be recom-
med. The use of desensitis-
ing toothpastes prior to, during and following tooth-whitening procedures has also been rec-
commended and this is particu-
larly important for patients with a known history of DH who may be undergoing such pro-
cedures.9,10

Over the last decade a num-
ber of new product innovations have come to the market, for example the combination of
casein phosphopeptides (CPP) and amorphous calcium phos-
phate (ACP) Recaldent (CPP
ACP, GC America, Inc.) has been
to reduce DH. ACP has also been used in bleaching trays to reduce DH during the bleaching process. Products have been developed from bioactive and bio-com-
patible glasses that are known to induce osteogenesis in physiological systems and may offer suitable materials for surface reactivity that could theoretically occlude tubules. NovaMin (calcium sodium phospo-
silicate) is a new product
formulation found in a vari-
ty of dental products for sen-
sitive teeth, such as NacCare
Prophy Paste (Sunstar Butler)
and professional use (NovaMin
Technology, Inc.).11,12

According to Gillam,1 techn-
ology based on a combination of
an amino acid arginine and an insoluble calcium carbonate compound (Pro-Argin) has re-
cently been developed as a de-
sensitising paste for use in the dental surgery as an OTC toothpaste product (8 per cent arginine, calcium carbonate, and 1.450 ppm fluoride as so-
dium monofluorophosphate). This technology appears to have been based on previous work by Kleinberg13 and it has previ-
ously been suggested that at
physiological pH the positively charged arginine in the combi-
nation binds to the nega-
tively charged dentine surface, thereby encouraging a calcium-rich mineral layer into the open (exposed) dentine tubule, act-
ing as an effective plug or tubu-
lar occlude. Initial laboratory (in vitro) evidence appears to support this in that the product does occlude the dentinal tubules and effectively block fluid flow and is resistant to an acid challenge.14 Evidence from subsequent clinical studies
appears to support its effi-
cacy as a desensitiser.15,16

For generalised sensitivity involving several teeth, OTC toothpastes containing potas-
sium (nitrate, chloride and citrate) and strontium-based products (strontium/stromium acetate/fluoride) have been shown to be clinically effective in well-controlled clinical studies, and are readily avail-
able to the consumer. Ac-

ning preventative and manage-
ment strategies in identifying and elimi-
ating predisposing factors in partic-
ularly erosive factors (such as dietary acids) cannot be ignored...”

Contact Info

www.medicom-asia.com

Product for home use. For the
dental professional who wishes
to be successful in treating the
condition it is important to re-
alise that there is no ‘one size fit
panacea for the treatment of this
condition but rather a se-
lected armamentarium of prod-
ucts and procedures. It is im-
portant therefore for the dental
professional to have a man-
agement strategy that is based on
a thorough history and exami-
nation, leading to a definitive
diagnosis that involves not
only the removal of any aeti-
ological and predisposing fac-
tors, but also careful monitor-
ing of the condition following
initial treatment. To this end, a number of treatment para-
digms have been suggested by researchers (Fig. 1, page
12).12,14,18 However, it is impor-
tant that the management of the condition fits in with the
day-to-day running of the indi-
vidual practice rather than
cause an unnecessary burden
on both the dental professional
and patient.

Conclusion

From reviewing the avail-
able literature on the condition it is apparent that the availabil-
ity of a vast array of treatments would indicate either that
there is no one effective desen-
sitising agent for completely resolving the discomfort or that the condition, owing to its highly subjective nature, is dif-
ficult to treat irrespective of the available treatment options.
The importance of implement-
going preventative and manage-
ment strategies in identifying and eliminating predisposing factors in particularly erosive factors (such as dietary acids) cannot be ignored if the dental professional is to treat this troublesome clinical condition
 SUCCESSFULLY.

Editorial note: A complete list of refer-
ences is available from the publisher.

Contact Info
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The keys to early cancer diagnosis

Dr Sara Gordon
USA

The young man was just 19 when he came in to see his dentist after Halloween because of a sore on the side of his tongue. A non-smoker and non-drinker, he did not seem to be at risk for cancer, so his dentist decided to re-check the lesion before Christmas. By then the lesion was bigger. When he finally had a biopsy in January, the lesion proved to be an invasive squamous cell carcinoma. Oropharyngeal cancer continues to claim the life of about one American every hour, accounting for 7,590 deaths in 2008, according to the American Cancer Society. Oral cancer was among those cancers that persist for more than ten days should be biopsied.

Lichen planus, or lichenoid mucositis, has generated heated debate about its pre-malignant potential for years. It is now recognised that there are several conditions that can share the clinical appearance of lacy white lines on a red background and also the microscopic feature of a dense T-lymphocyte infiltrate along the basement membrane. Lichenoid conditions are probably not all equally likely to generate squamous cell carcinoma. A lichenoid drug reaction, for example, is a reaction to a systemic medication that disappears when the medication is withdrawn. Lichenoid reactions can also result from contact with an allergenic material, such as a metal, in susceptible patients (Fig. 5), and for other reasons.

There are many reports in the literature of cancer arising in a patient previously diagnosed with lichen planus, but some retrospective analyses have confirmed that the original clinical
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are caused by HPV. Renal members of this group include verruca vulgaris, the common wart (Fig. 6), which is self-limiting in most patients, and condylomata, genital warts (Fig. 7), which can be widespread in the immunosuppressed patient.

There are also pre-malignancies and malignancies in this group. Proliferative verrucous leukoplakia (PVL) is a multifocal verrucous disease that eventually turns into carcinoma in a substantial proportion of cases. Figure 1 may represent a case of PVL. Verrucous carcinoma is a large warty malignancy that is slow to invade but can degenerate into squamous cell carcinoma.

Several commercial chairside applications, such as toluidine blue staining, tissue reflectance, fluorescence imaging and brush tests, have appeared on the market in the past decade, which are intended to help the dentist with early cancer detection. Despite their attractive marketing and convenience, they have not been proven by rigorous Cochrane analysis to either help or hinder early cancer detection in the general population. Even visual screening programmes have not been proven to help reduce oral cancer deaths, and more study is needed in this field. Table 1 summarises the currently available adjunctive technologies.

This leaves the dentist with a very powerful tool: the biopsy, which is still the only technique that definitively diagnoses oral cancer. When combined with a detailed patient history, as well as a thorough head and neck examination, it can allow the dentist to diagnose oral lesions with as much confidence as possible.

A biopsy is simply the removal of tissue from a living patient for the purposes of diagnosis. Whether the tumour is a scalpel, surgical scissors or a surgical punch, the aim is to retrieve a piece of tissue that is representative of the entire lesion and preserve it en route to the oral pathology laboratory (Fig. 8). At the laboratory, the specimen is processed on a glass slide and diagnosed microscopically. Usually it takes a week or less for the oral pathologist to finalize the biopsy report.

The American Academy of Oral and Maxillofacial Pathology recommends that for aesthetic and functional reasons all tissue removed from the oral cavity be sent to an oral pathologist as a biopsy, unless it results from a routine procedure, such as a gingivectomy. Most oral pathologist’s services are covered by the patient’s medical insurance. General pathologists will also accept biopsies from dentists; however, it should be considered that oral pathologists receive at least three years of specialty training after dental school and are truly specialists in oral disease.

By routinely examining every patient thoroughly for signs of head and neck cancer, and ensuring that any potentially suspicious lesion persists for more than ten days is appropriately biopsied and sent to an oral pathologist for diagnosis, dentists may indeed save lives.

Editors’ note: A complete list of references is available from the publisher.

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<table>
<thead>
<tr>
<th>Technique</th>
<th>Example of common brand name</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tissue reflectance</td>
<td>Vizilite</td>
<td>Enhances the appearance of white areas</td>
</tr>
<tr>
<td>Tissue autofluorescence</td>
<td>Velscope</td>
<td>Abnormal tissue loses normal green autofluorescence, appears black</td>
</tr>
<tr>
<td>Brush test</td>
<td>Oral CDx</td>
<td>Superficial epithelial sample is classified as positive, negative or atypical</td>
</tr>
</tbody>
</table>

Table 1: Commercial techniques intended to aid oral cancer detection.

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Testing the bluephase 20i

A user report on the new bluephase 20i LED light

Dr. Niklas Bartling
Switzerland

We have been using a first-generation bluephase LED light for more than two years in our dental practice. This curing light offers a light intensity of 1,200 mW/cm² and achieves a wavelength range similar to the spectrum of halogen lights, owing to its poly-wave LED technology.

There was therefore no need to purchase a new light unit. Nonetheless, I let myself be persuaded into testing the bluephase 20i for three weeks in my practice, focusing on assessing the light’s performance in the Turbo programme when used at a maximum light intensity of 2,000 mW/cm².

In the past, several suppliers offered curing lights that were claimed to provide high light intensities and short polymerisation times. Unfortunately, most of these lights failed to live up to these claims when they were evaluated in field tests. Against such a background, the employees in my practice were less than enthusiastic about conducting the trial. To overcome their resistance, they were first shown how to operate the four programmes of the bluephase 20i light. In addition, we drew up a table of all the materials that would be used in the trial and their respective curing times in conjunction with the Turbo programme (Fig. 1).

Normally, we select the curing programme individually at each step in the treatment together with the dental assistant. It transpired that the well-known bluephase programmes—High, Low and Soft modes—were used whilst the Turbo programme of the bluephase 20i was studiously avoided.

Reclaiming trust

The objective of our field test was to identify the limitations of the new LED light. Given the reservations of the team members, we decided to establish first the depth of cure achieved using the Turbo programme of the bluephase 20i. It was hoped that this would dispel the objections of the team members. The Heliotest kit, which used to be available for the fabricating of custom-made shade samples, is no longer manufactured. We therefore created our own test samples by cutting an approximately 1 cm-long piece from a straw. Next, we pressed a small amount of low-viscosity silicone into one side of this piece of straw and allowed the material to set. Then, we inserted the piece of straw into an empty composite syringe and filled the syringe with composite.

If a light probe is placed on the composite and the material is polymerised, the depth of cure can be established as an alternative test method.

As it is not always possible to place the light probe directly onto the tooth in dental applications, I increased the distance to the material with a matrix in the course of conducting my tests. The results were unambiguous: the bluephase 20i successfully passed all test series conducted with the Turbo programme in conjunction with the composites used in our practice.

I repeated the tests in front of the practice team with good effect and all reservations regarding the Turbo programme and its short curing time of five seconds suddenly vanished. From then onwards, nothing hindered the Turbo programme being used routinely. On the contrary, this programme became very popular amongst the team members and they used it frequently. The usual waiting times associated with the layering technique decreased drastically and swift working during light-curing was soon established. All team members repeatedly commented on the substantial amount of time that can be saved by reducing the polymerisation time from twenty to five seconds.

Field test in the dental practice

Several patient cases treated during the trial phase of bluephase 20i are described below to provide examples of how the new light unit may work.

In the first case, two definitive restorations had to be replaced, one on the distal side of tooth 11 and the other on the mesial side of tooth 12 (Fig. 2). The defective fillings were removed and the cavities filled with BioComposite (Figs. 3 & 4). Next, the restorative material was polymerised using the Turbo programme of the bluephase 20i (Figs. 5 & 6). As can be seen on the pictures, the composite was polymerised successfully and the composite fit perfectly with the tooth. The Heliotest performed a successful test on the composite. Additionally, it was observed that the light probe could not always be placed in an optimal position. With the Turbo light probe (10 > 8 mm), the curing time only increased to 2×5 seconds (Fig. 6).

In the second patient case, a gap between two anterior teeth had to be closed. Veneers made of IPS Empress Esthetic were selected for this purpose. Fig. 6 shows the ceramic veneers and Variolink II are polymerised using the Turbo programme (five seconds per mm of ceramic). It is advisable to protect the margins with Liquid Strip.

For the materials used in the trial, the curing times in conjunction with the Turbo programme of the bluephase 20i were:

<table>
<thead>
<tr>
<th>Material</th>
<th>Curing time in conjunction with the Turbo programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetric EvoCeram / Tetric EvoFlow / IPS Empress Direct</td>
<td>5 s</td>
</tr>
<tr>
<td>Composit Flex / Composit Flow</td>
<td>2x5 s</td>
</tr>
<tr>
<td>Variolink II* / Variolink Veneer*</td>
<td>5 s per mm ceramic and per segment</td>
</tr>
<tr>
<td>Multilink Automix**</td>
<td>5 s per segment</td>
</tr>
<tr>
<td>Heliosit Orthodontic</td>
<td>2x5 s</td>
</tr>
</tbody>
</table>

* applies to base paste only; ** applies to dual-curing

Esthetic veneers placed on teeth 13 to 23 and bleaching of the mandibular teeth.

Correlation between the curing light and the composite: The curing light offers a light intensity of 1,200 mW/cm² and achieves a wavelength range similar to the spectrum of halogen lights, owing to its poly-wave LED technology. It is not always possible to place the light probe directly onto the tooth in dental applications, increasing the distance to the material with a matrix. The results were unambiguous: the bluephase 20i successfully passed all test series conducted with the Turbo programme in conjunction with the composites used in the practice. The team members repeatedly commented on the substantial amount of time that can be saved by reducing the polymerisation time from twenty to five seconds.
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light probe cannot always be positioned directly onto the tooth. It is therefore essential to use a high-performance polymerisation light to ensure a complete depth of cure in every situation. The polymerisation time only has to be doubled if the distance between the composite and the light emission window is larger than 8 mm if a Turbo light probe (10 > 8 mm) is used.

Furthermore, the blue-phase 20i provides a clear advantage when treating children. In such cases, swift working is of paramount importance to prevent the treatment from turning into a struggle. Reducing the polymerisation time to twice five seconds in conjunction with Compoglass F is very helpful in these circumstances.

Light-curing through ceramic
Ceramic restorations are usually more opaque than composite ones. If a luting composite is light-cured through an all-ceramic restoration, the polymerisation time has to be increased to ensure complete polymerisation. In this case, we had to close a gap between two anterior teeth, as the patient was unhappy with the appearance of the teeth (Fig. 7). The patient did not desire orthodontic treatment. As an alternative, we decided to insert IPS Empress Esthetic veneers. If the Turbo programme of the bluephase 20i light is used, a polymerisation time of five seconds for each millimetre of ceramic and for each segment is required (Fig. 8). Given the high power of this curing light, a few glimpses of doubt emerged at times. In particular, concerns around heat development during polymerisation were voiced. We asked ourselves if the gingival tissues might suffer thermal damage during polymerisation. To clarify this issue, we lighted on my tooth necks irradiated with the light strength of the Turbo programme for five seconds. I then took the light probe and placed it directly onto my gingiva without help. During all these cycles of irradiation I did not feel the slightest heat-induced pain. Similarly, none of the patients complained about pain when cervical restorations were cured with the bluephase 20i, even when the restorations were inserted without anaesthetic.

Conclusion
Although I had a few reservations at the beginning of the trial, I was satisfied with the bluephase 20i in every aspect. All composites can be reliably cured, as this curing light emits light in a similar spectrum as halogen lights. In addition, the Turbo programme offers substantial time-saving when treating patients.

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The search for an effective fluoride toothpaste utilisation formula

An interview with Dr Michael Antonio F. Mendoza, the Philippines

The effective use of fluoride for the prevention of dental caries is advocated by organisations like the WHO and the FDI. In most Asian countries, fluoride toothpaste is often the only affordable source of fluoride for the general population. In early 2008, a cross-sectional study was conducted in the Philippines to evaluate the utilisation of fluoride toothpaste in the country. Dental Tribune Group Editor Daniel Zimmermann spoke with Dr Michael Antonio F. Mendoza, Assistant Professor at the College of Dentistry of the University of the Philippines in Manila, about the study and the challenges of making the use of fluoride toothpaste more effective.

Daniel Zimmermann: Dr Mendoza, is tooth brushing with fluoride toothpaste common routine in the Philippines?

Dr Michael Antonio F. Mendoza: Toothpastes available in the Philippines are generally fluoridated and most people use such toothpaste when they brush their teeth. However, it is not uncommon in certain parts of the population to clean teeth without toothpaste. A toothbrush, washcloth or even a twig is used with or without alternatives to dentifrice, such as salt, sand, ash or just water.

A study was conducted on the use of fluoride toothpaste in two Filippino barangays (villages). What were the objectives of the study and what were its findings?

With an initial objective to present oral health policy options to the local government, baseline data on fluoride utilisation patterns was first required. Toothpaste is the primary fluoride source for most barangays. Therefore, we selected a peripheral barangay and a central barangay in the city of Malolos, which is located 45 km north of Manila.

Household health managers were interviewed on their knowledge, attitudes and practices regarding oral health, particularly fluoride use. We also questioned them on the amount of toothpaste dispensed, the frequency of use and whether rinsing was done after brushing.

All interviewed health managers who are dentate brush with fluoride toothpaste. A hot dog-sized amount was used twice to three times a day, followed by rinsing with water. We also found that the use of kiddie toothpaste was not an established practice.

What effect does the rinsing habit have on the benefits of fluoride toothpaste?

Almost all respondents and their family members rinsed with water after brushing with toothpaste. Therefore, the effects of fluoride were not optimised, as was evident from an observed trend of increasing DMFT score with increasing age.

Were there any differences with regard to age and gender?

Three out of four respondents were female, as mothers are usually considered to be the household health managers. All claimed to use fluoride toothpaste regardless of gender. DMFT scores were higher in the peripheral barangay. However, there was only a significant difference in the age group 55 to 44, for which the peripheral barangay had a higher caries level compared to the moderate level of the central barangay.

The study was conducted in early 2008. What has been done in the last 12 to 16 months to address the problem?

Workshops were held in collaboration with the Youth Council and the mother leaders to increase their knowledge of oral health and, hopefully, their capacity to communicate the knowledge gained to other members of the community. The results of the study were discussed with the communities who participated in the study and members of the City Council involved in the planning and implementation of the research. However, no specific oral health programmes have been established.

In your opinion, what are the main challenges of increasing the effectiveness of brushing with fluoride toothpaste in countries like the Philippines?

As I mentioned before, Filipinos generally use fluoridated toothpastes but improper brushing techniques and poor awareness of its benefits negate the preventive potential of fluoride. Re-education of patients and re-orientation of dental professionals on the optimal use of fluoride, particularly fluoridated toothpastes, is required.

Only seven per cent of the population in the Philippines receives fluoridated drinking water. Could increased levels of fluoride in water be of any help to the problem?

The National Oral Health Survey of 2006 found a very low, naturally occurring fluoride content in drinking water, which was also evident in tests of water samples from Malolos.

Although literature indicates that it would be the most cost-effective in terms of prevention, infrastructure costs and water system modification for water fluoridation would be too prohibitive.

Most countries in the Asia Pacific region have conditions similar to those in the Philippines. What are your recommendations in this regard?

We need to investigate more practical and cost-effective preventive measures. The proper use of fluoride toothpastes needs to be practised and steps to make fluoride toothpastes more affordable, as the WHO advocates, should be taken.

Thank you very much for the interview.
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