Global trends in focus of World Dental Forum

Dental laboratory giant invited to Mainland China and Macao

Daniel Zimmermann

HONG KONG/LEIPZIG, Germany: Affiliates of Modern Dental Laboratory (MDL) have recently met during the World Dental Forum in Shenzhen and Macao in China. The event also saw more than 200 dentists from Europe, North America and Asia gathering for three days of learning and discussing new trends in the global dental industry. Chinese dentistry representatives and other professionals including the dean of Hong Kong’s Faculty of Dentistry Prof. Professor Lakshman Samaranayake attended the meeting.

MDL is one of the largest providers of dental restorations in China and pioneer for the outsourcing of manufacturing which has become an increasing trend in Europe and even more in the United States.

According to Chinese lab consultant Ma Yun Xi, there are now more than 8,000 dental labs of different sizes in China alone of which 100 are able to provide qualified services for clients in overseas. MDL, has been producing ISO 13485:2003 certified dental work for dentists and patients in the US from its main lab in Shenzhen since 1976. The company also says to maintain the largest dental technology school worldwide with a staff of 3,000.

“It was thrilling to bring a group of dentists from the US to Modern Dental Laboratory during the World Dental Forum, allowing them to see firsthand how worldwide dentistry is positively reaching US dentists and patients today,” said Patrick Tressier, CEO of Modern Dental Laboratory USA. “Many of the doctors told me that what stood out for them during the tour is that there is a quality check after every process, not just at the final restoration.”

MDL said that the company will held its next Forum in conjunction with the centennial celebrations of the University of Hong Kong in 2012.

Dental laboratory giant invited to Mainland China and Macao

First Afro-American takes presidency

The American Dental Association has elected Dr Raymond F. Gist, a dentist from Flint, Michigan, as their new president. Gist is the first African-American to hold the organization’s highest elective office. He announced to focus on membership outreach and advocacy efforts that will have special appeal to young dentists.

India, Malaysia agree to free trade

India and Malaysia have agreed on a new free trade deal that will take effect in mid-2011. The Comprehensive Economic Cooperation Agreement covers trade in goods and services, investment and economic cooperation. It is expected to be signed by end of January next year, according to a joint-statement.

Displaced dental workers given help

The Filipino Department of Labor and Employment has announced that it will provide financial and livelihood assistance to the 50 dental technicians left unemployed by the closure of a Manila lab in August. It also said to have teamed up with the National Association of Dental Prosthesis Laboratories to seek training opportunities and possible future employment for the rest of the 400 workers in other dental laboratories in the country.

The facility concerned was according to a joint-statement.

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DTI
A well-recognised health profession

Prof. Lakshman Samaranayake talks about the University of Hong Kong Faculty of Dentistry

Established in 1980, the University of Hong Kong’s Faculty of Dentistry is not only one of the youngest but also fastest growing dental schools in Asia. Recently, the school opened a new Centre for Advanced Dental Care that aims to provide higher clinical training to students and visiting dentists. At the Open Day in November, Dental Tribune Asia Pacific spoke with the Dean, Prof. Lakshman Samaranayake, about the Faculty and what makes studying Dentistry at the University of Hong Kong unique.

Dental Tribune Asia Pacific: Since 1997, Hong Kong has been administered by the People’s Republic of China. Did this have an influence on the Faculty and Hong Kong dentistry in general?

Prof. Lakshman Samaranayake: The handover had a major impact on our relations with the key academic institutes in Mainland China. In collaboration with the Beijing University School of Stomatology, for example, the Faculty initiated the Mainland’s first ever joint international clinical programme in advanced Periodontology in 2007. We have also initiated joint Annual Fellowships in Advanced Dentistry together with the Chinese Stomatological Association and established the Wah-Ching China Dental Sciences Development Project.

Where do the majority of your students come from and do you cooperate with other universities abroad?

The vast majority of our undergraduate students are local, and only a minority come from Mainland China or the region. However, we are proud to say that we have over 200 postgraduate students from over 50 nations registered in the Faculty right now and at least the same number of agreements with major universities overseas to promote academic research and cultural exchange. In the last two years, the Faculty has been also regular host to dental school representatives from around the world, and signed academic and research collaboration agreements with dental schools in Thailand, Finland and the US, amongst others.

How many Dentistry students graduate from the Faculty each year and what are their overall job prospects?

Each year, around 50 dentists graduate from our school. They are able to pursue a career in private general or specialist practice, hospital dentistry, government dental services, or teaching or research.

Dentistry is a well-recognised health profession in Hong Kong and dental graduates have the benefits of a high professional status, as well as an above-average income. Dental graduates from the Faculty normally secure gainful employment in the field of dentistry shortly after graduation. In 2009, all Bachelor of Dental Surgery (BDS) graduates found jobs or pursued further studies within the first six months of graduation. Let me add that more than 50 per cent of dentists in Hong Kong are alumni of our Faculty.

You rival with other dental schools in Asia. In your opinion, what makes dental training in Hong Kong unique?

Our training is unique for a number of reasons but I think one of the main things that makes us different is that we use English as main instructional language. Our teaching staff also comes from more than ten different countries and they enrich the courses with international knowledge. The Faculty is also one of the best equipped in Asia, with students having the latest digital technology at their disposal.

Last but not least, we are the only dental education facility in Asia that offers Problem-Based Learning (PBL) programmes for undergraduates.

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Asian experts discuss implants at German meeting

Daniel Zimmermann

LEIPZIG, Germany: Over 180 dentists from Asia, Germany and the UK recently discussed new concepts in restorative implant dentistry at a joint symposium held at the University of Tübingen in Germany. Japanese scientists led by Prof. Takashi Miyazaki from Showa University presented new research on utilising spark erosion for the improvement of implant surfaces. The technology is currently being used in other industrial fields for cutting metal using high voltage electronic discharges.

Dental implantology has seen an upswing in countries like Korea and China, where more than 80 of all dentists are now able to place implants. According to Prof. Yen Lin of the School of Stomatology at the Beijing University in China, who also attended the meeting, between 2,000 and 3,000 implants are placed in the clinic’s Department of Implantology each year.

Industry reports predict that the market will grow to over US$125 million by 2013, reflecting a compound annual growth rate of more than 50 over the next four years.

The symposium, chaired by Clinical Director Prof. Heiner Weber, was organised by the Department of Prosthodontics at the University of Tübingen. Since the 1980s, the university has been educating dentists, technicians and dental students from different parts of Asia in dental surgery.

Asia, Europe take on fake drugs

Daniel Zimmermann

LEIPZIG, Germany: Politicians and business leaders participating in the Asia–Europe Summit ASEM 8 in Brussels in Belgium have decided to strengthen trans-regional cooperation in health care services between Asia and the European Union. They have also called for improved intervention policies on counterfeiting, including the recognition of Good Manufacturing Practice certification by Asian countries.

Counterfeit goods, including medical products, account for US$200 billion or 2 per cent of the world’s trade, according to figures from the Organization for Security and Co-operation in Europe. Many of them originate in countries like India and China, where restrictions against counterfeiting are ineffective. Amongst others, the US Food and Drug Administration had to recall tons of counterfeit Colgate toothpaste in 2007, which were produced in China and contaminated with a chemical compound commonly used in antifreeze.

“Counterfeit medical products are not only of concern to dentists and the dental industry. They represent a threat for all medical professions,” Friedrich A. Herbst, Executive Director of the Association of International Dental Manufacturers told Dental Tribune Asia Pacific. “The spread of counterfeit products can only be reduced when each and every individual along the distribution chain is committed to ensuring that the product or good he is offering, distributing or selling comes from a reliable source which is known for its personal integrity and ethical standards.”

Herbst added that the World Health Professions Alliance, a non-governmental body representing over 600 health organisations around the world, recently announced a public health alert on the prevalence of falsified medical products. The organisation also provides resources on their website (www.whpa.org) for physicians and dentists seeking more information on the matter, he said.

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Dear reader,

There is no doubt that counterfeiting has become a serious problem not only for the industry but consumers alike. Fake medicine, originating mainly from countries like India, China or South Africa, even poses a increasing threat to public health, according to the World Health Organisation.

Despite a few tons of fake toothpaste and mouthwash, dentists have long been spared by the trend in the globalised dental industry for outsourcing production to low-wage countries. There is no doubt that consumers alike. Fake medicine, originating mainly from countries like India, China or South Africa, even poses a increasing threat to public health, according to the World Health Organisation.

Against fake products has to be well-being. Therefore, the fight against fake products has to be aware of this relationship and be aware of this relationship and that what they sell or put in patients’ or consumer’s mouth can that what they sell or put in patients’ or consumer’s mouth can contribute to the advancement of knowledge.

The PBL-based dental curriculum aims to prepare graduates in such complex real-life situations. This approach allows us to expose students to all sciences (dental, biomedical, behavioural and social) linked with dental surgery.

We believe that these principles, evident in other components of the BDS programmes, make it easier to acquire and retain knowledge across different disciplines, instil life-long learning habits, as well as foster teamwork skills and train students to deal with complex real-life situations. The PBL-based dental curriculum aims to prepare graduates in such complex real-life situations. This approach allows us to expose students to all sciences (dental, biomedical, behavioural and social) linked with dental surgery.

Yours sincerely,

Daniel Zimmermann
Group Editor
Dental Tribune International

Clinical controversies in implant dentistry

Lisa Townshend
Dental Tribune UK

More than 5,000 dentists, dental clinicians and implant specialists from around the world met in Glasgow to discuss some of the very latest techniques in implant therapy at the 19th annual scientific congress of the European Association for Osseointegration (EAO).

With a truly international flavour, the four-day congress focused on the science related to dental implants. The range of topics covered was extremely varied and multi-disciplinary, discussing aesthetics, use of CAD/CAM, quality of life factors, periodontal therapy, prosthodontics etc. Saturday morning’s session was even focused on ‘controversial’ issues including implant placement adjacent to and within endodontically infected sites or when and how to connect implants to teeth.

In addition to the main sessions, there was a comprehensive parallel session programme, short oral communication sessions and more than 550 poster presentations covering six topics such as implant therapy outcomes, surgical aspects, tissue augmentation and material research.

The Association itself had much to celebrate as it unveiled its new identity to better reflect the advanced scientific knowledge and cutting edge technology of its members and the profession. The EAO showcased a bright new logo and distinctive colour scheme, designed to project a more dynamic feel to the association. The conference seemed to be buzzing from the start, with many delegates commenting on the new brand and the high quality of the speakers.

The EAO is now looking forward to its 20th annual conference next year, to be held in Athens, Greece 15-15 October 2011. 

Lisa Townshend is the Group Editor of Dental Tribune UK. She can be contacted at lisa.townshend@dentaltribuneuk.com.
Athens hosted World Congress in endodontics

Daniel Zimmermann
DTI

ATHENS, Greece/LEIPZIG, Germany: New findings in evidence-based endodontics were recently discussed at the World Endodontic Congress in Athens in Greece. The event, which took place in early October and was organised by the International Federation of Endodontic Associations (IFEA), also saw new products launched, including a number of newly improved reciprocating files that are said to be more tolerant to circular fatigue.

Speakers included experts from Europe and the Middle East, as well as North and South America, who lectured on current issues in the field such as effective root-canal debridement and disinfection techniques that improve the success of root-canal treatment. Other presentations explored the use of 3-D imaging and microscopes during endodontic procedures. Dr Gabriela Martin, a clinician from Argentina, and many others presented new evidence for regeneration of the pulp. Until now, pulp revascularisation has been largely considered impossible owing to the presence of bacteria in the root canal.

IFEA is an umbrella organisation comprising 26 national endodontic associations worldwide. According to its statutes, the organisation aims to promote endodontic education on a global scale through congresses and lectures. The organisation’s World Congress is held every three years.

UK dental students face higher fees

Lisa Townsend
DT UK

LONDON, UK: Members of the House of Lords have recommended an increase in university tuition fees in the UK. Reports in the media also suggest that the new coalition government aims to cut university budgets by £82 million (US$130 million) next year and that the number of student places available is to be halved.

The proposed changes hold far greater implications for dental and medical students, as their courses are significantly longer than the usual three years. Recently, figures of £7,000 (US$11,050) per year have been mentioned; however, there is also talk of an unrestricted annual fee to be determined by individual universities. Should these changes be effected, then students would potentially leave university with a staggering amount of debt.

As it stands, many students struggle to find a job after graduation owing to the economic climate, resulting in their being burdened by ever-increasing debt on their student loans. Thus, increased loans as a result of increased fees and no certain way off paying such debt off will undoubtedly put off prospective students. A decrease in the number of future dental and medical university students however could result in a sudden shortage of trained professionals in the future and ultimately affect economic growth. Figures suggest that, in the UK between 2000 and 2007, the increase in employed university graduates accounted for six per cent of growth in the private sector.

It is believed that were the proposed changes to be implemented, elite universities, where students compete for places, would end up charging higher fees for the privilege. However, in the case of dental and medical students, it appears to be common opinion that they are guaranteed a job that is well paid and because of this they leave university in a better position to pay back their fees.

(Edited by Daniel Zimmermann, DTI)

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(Edited by Daniel Zimmermann, DTI)
LONDON, UK: The 10th Biennial Meeting, held in London, was a truly collaborative effort. Organised by the European Association of Oral Medicine and the three London dental schools (King's College London; Queen Mary, University of London; and University College London's Eastman Dental Institute) and supported by GSK, the conference highlighted the importance of oral medicine in diagnosing and treating conditions such as xerostomia and hyposalivation. The opening plenary session of the main part of the conference was dedicated to this topic.

After opening remarks by Baroness Gardner of Parkes and Chief Dental Officer for England Dr Barry Cockcroft, it was time to turn over the session to the two Chairs, Prof. Isaac van der Waal (Head of the Department of Oral and Maxillofacial Surgery and Oral Pathology of the VU University Medical Center/ACTA Dental School, Amsterdam) and Prof. Crispian Scully CBE (Director of Special Projects at the UCL Eastman Dental Institute, and Professor of Special Care Dentistry, University College London). After setting the scene for the session, they introduced the first speaker, Prof. Stephen Porter.

Prof. Porter is Director and Professor of Oral Medicine at the UCL Eastman Dental Institute. In his presentation, "Hyposalivation: Prevalence, assessment, differential diagnosis and quality of life impact," he gave a general overview of the condition of xerostomia in terms of prevalence. He discussed the age factor in the condition, as well as issues such as immunosuppressant disease and drug/radiotherapy treatments. He also looked at the issue from the point of view of the patient, whose quality of life may be affected because of reduced sleep and impaired eating function.

Next to speak was Dr Jackie Brown, specialist in Oral and Maxillofacial Radiology. She is Consultant in Dental and Maxillofacial Radiology at Guy's and St Thomas' NHS Foundation Trust; and is Senior Lecturer at King's College London Dental Institute, of Guy's, King's College and St Thomas' Hospitals, and at the UCL Eastman Dental Institute. In her presentation, "Contemporary imaging in salivary gland disease diagnosis," she considered the role of imaging in the distinguishing and identifying diseases affecting the salivary glands. She discussed the various imaging equipment available, including ultrasound and CBCT, as well as their advantages and disadvantages.

Then it was the turn of Prof. Gordon Proctor (Professor of Salivary Biology and Head of Salivary Research Unit, Department of Clinical Diagnostic Sciences, King's College London Dental Institute), who discussed "Drug-related hyposalivation: A review of physiology and sites of drug action." Prof. Proctor highlighted the relationship between drug therapy and salivary flow rates. He discussed the findings from various studies looking at this relationship, including one specific paper by Wolff et al., which was referenced in his presentation. Wolff et al. conducted a study to investigate the effect of various medications on saliva flow rates, revealing that some drugs can significantly reduce saliva production. This information is crucial for dentists and patients, as it helps in the management of conditions related to xerostomia and hyposalivation.
Major salivary gland output differs between users and non-users of specific medication categories (published in Gerodontology 25/04, 2008).

Speaking just before the coffee break was Prof. Jennifer Webster-Cyriaque (Associate Professor, Departments of Dental Ecology and Microbiology and Immunology, Schools of Dentistry and Medicine, University of North Carolina at Chapel Hill). In her presentation, Viral infections of salivary glands resulting in hyposalivation, she examined various viral infections that can affect saliva production, including HIV, herpes and polyomaviruses (such as BKV). One of the main challenges, according to Prof. Webster-Cyriaque, is determining the manner in which viruses access and infect the salivary cells.

Following the coffee break, during which delegates had the opportunity to network and discuss the morning’s presentations, Prof. Roland Jonsson, Vice-chairperson of the Gade Institute at the University of Bergen, gave a presentation on Immunopathology resulting in hyposalivation. He focused mainly on Sjogren’s syndrome, stating that it is a condition that is not easy to diagnose in its early stages. He stressed that biopsies are very important for the diagnosis and understanding the pathogenesis of the condition. Detailing various studies, Prof. Jonsson hypothesised that a virus might trigger the inflammation.

Also focusing on Sjogren’s syndrome, Dr Elizabeth Price followed Prof. Jonsson’s presentation with Systemic disease associations of hyposalivation. Dr Price has a specialist interest in Sjogren’s syndrome and runs a specialist Sjogren’s clinic at the Great Western Hospital in Swindon. She discussed the condition in more detail, and highlighted that along with dry eyes and mouth, tiredness and fatigue are common symptoms. She also discussed the condition’s association with thyroid disease and osteoarthritis.

Next, Prof. Sue Lightman (Medical Research Council Senior Clinical Fellow, Senior Lecturer at the Institute of Ophthalmology and Consultant Ophthalmologist at Moorfields Eye Hospital in London), considered Ocular associations of hyposalivation. She detailed the manner in which dry eyes can rapidly arise and the way in which conditions such as Sjogren’s syndrome originate.

The final speaker of the session was Dr Philip Fox, Visiting Scientist at the Department of Oral Medicine, Carolinas Medical Center in Charlotte, USA, and an independent biomedical consultant primarily in the area of clinical trial design and analysis. This was the practical part of the session, as it focused on the treatment of patients suffering from xerostomia. According to Dr Fox, clinicians must remember that their primary aim is to treat patients. To this end, clinicians can encourage patients to chew and stimulate the masticatory function.

Dr Fox also considered different ways of managing xerostomia, including different formulations, such as Biotene, produced as gels, gums and mouth rinses. He concluded by reminding the audience that their patients and what makes the mouth feel moist and comfortable for them are the most important issues for clinicians.

This session offered a very detailed examination of some of the causes of xerostomia and hyposalivation and allowed delegates to gain a better understanding of the manner in which these conditions affect saliva flow. It also offered delegates an update regarding the rationale for many of the products clinicians could recommend to patients for relief.

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foreign markets are very important to us
An interview with Olaf Sauerbier, CEO of VOCO GmbH, Cuxhaven, Germany

“Foreign markets are very important to us”

Ad

dentistry.

about new products and aes-

chief of Marketing and Sales,

of prosthetics and prophylaxis.

offers a wide range of materials

materials. In addition to prod-

the northern coast of Germany,

Areal view of the VOCO headquarters

in Cuxhaven in Germany.

VOCO, based in Cuxhaven on

the northern coast of Germany,

an established international

provider of high-quality dental

materials. In addition to prod-

ucts for restorative dentistry, it

offers a wide range of materials

and preparations for the fields

of prosthodontics and prophylaxis.

Dental Tribune Group Editor

Daniel Zimmermann spoke

with Olaf Sauerbier, CEO and

Chief of Marketing and Sales,

about new products and aes-

thetic trends in restorative
dentistry.

Daniel Zimmermann: The

Association of Dental Dealers

in Europe (ADDE) has recently

predicted growth rates above

three per cent for most Euro-

pean dental markets. Do you

see any signs of recovery in

your company?

Olaf Sauerbier: To be honest

with you, the recession never

really caught us. We usually tend

to perform slightly better than

the overall market and expect to

be no different for this business

year. The year 2010 started off

better than last year ended, and

we saw some significant growth

in most of our business segments

in the first and second quarters.

Although we have invested

significantly in our Ger-

man businesses by ex-

tending our sales team

by 15 new employees,

foreign markets are very

important to us. At the mo-

ment, we are expanding

our existing businesses

worldwide, especially in

North America. It will be

a while before we are able

to take full advantage of

the enormous potential

this market has to offer.

Did the products you

introduced two years

ago at IDS Cologne meet

your expectations?

The most important product we introduced at IDS in terms of sales was def-

inately the non-run, non-drip

NDT syringe. This new delivery

form helped us to increase sales

of most of our highly flowable

materials like Grandio Flow,

Grandio Seal and Jansenote. Our

gingiva-shaded restoration sys-

tem Amaris Gingiva has also

shown good performance. We

have to admit that the market for

such a product is still small, but,

on the other hand, we see the

demand for aesthetic restora-

tions of exposed necks of teeth

increasing owing to demogra-

phic changes and people ageing.

Those who have highly aesthetic

regard very well owing it hard to

pass this product by.

Another bestseller has been

the one-component, light-curing,

nano-reinforced, self-

etchbond Futurabond M

that we launched in

Sealab Postsys-

tem, an award-win-

ning complete system for placing

15 posts in post-endodontic treat-

ment, that sold successfully in

Germany and abroad within a

short amount of time.

Some segments in dentistry,

dental implants in particular,

have shown decreasing sales.

What is the situation in the market segments you are in-

volved in?

The recession might have had devastating effects on com-

panies offering upscale materi-

als and equipment but the situ-

ation in restorative and preven-

tative dentistry looks far more

promising. In the segments in

which we are actively involved,

such as prosthetics, prophylaxis

or dental cements, we have been

able to achieve growth rates

between 10 and 20 per cent.

Filling materials did not perform very well owing to in-

creased market competition.

There are plenty of new and in-

novative filling materials on the

market right now and we have

to invest a great deal in order to

stay ahead with new develop-

ments and products.

What current trends have you observed in the industry?

All manufacturers are striv-

ing for a product that offers

almost ideal properties for a

filling material and exhibits the

same physical properties as

natural tooth substance. All our

competitors are moving towards

this ideal but I see us far ahead.

We have been working with

nanotechnology since the early

2000s and based on the results

of this launched our first nano-

hybrid composite Grandio in 2005.

This product is still in high

demand in Germany and many

other markets.

But we did not stop there.

With GrandioSO, we are now

able to present another nano-

hybrid composite to the dental

community that has outper-

formed our original expecta-

tions. In terms of its physical

properties, it is probably the

most tooth-like material on the

market.

When and where will it be available?

It is already available in

Germany and other selected

European markets. Like its pre-

decessor, GrandioSO is univer-

sally applicable but a little more

translucent, so it can be used for

restorations in the maxillary

anterior region.

We will still offer Grandio

to our customers worldwide. In

the end, it is the dentists who de-

cide which product they offer.

Do aesthetics play a more prominent role in the develop-

ment of a composite like GrandioSO?

The primary goal is function. There is a place for aesthetics too, but it

must not compromise functionality or the stability of the filling. There

are different points of view in dentistry regarding this matter right now

but for us the primary goal cannot be highly opaque teeth that might

be currently in vogue amongst Hollywood stars.

In the US, for example, we found that dentists were using the white

opaque shade of our flowable composite Grandio Flow for ceramoplastics

as this is the typical shade of highly bleached teeth in the US. Nor-

mally, we recommend it only be used to whiten dark spots or in cases in

which dentists absolutely need an opaque layer.

This is not the direction we wish to take. Teeth have a natural translucency

and we want to keep it that way. I believe that with our current portfolio we offer

dentists viable solutions to achieving long-lasting and natural aesthetic

restorations.

Some European companies develop

their products especially for the North American market. Do you do the same?

We sell exactly the same products in North America as we sell in Eu-

rope. Usually, most products are launched there six months after they have been

placed on the European markets. The only difference is the type of shade.

In Germany, for example, the majority of dentists use Shade

A2,5, which does not play any significant role in markets like the

US, where Shade A2 is more common.

“Teeth have a natural translucency and we want to

keep it that way.”

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Will GrandioSO be the main focus of your presenta-

tion at IDS next year and are you planning to introduce

more products there?

No, we will be presenting the main focus of our IDS presenta-

tion, but there are other products that we plan to launch this month

and at IDS 2011.

Thank you very much for the interview.
A word from Jérôme Estignard, FDI Interim Executive Director

Mr Jérôme Estignard has been appointed Interim Executive Director by the FDI Council during the 2010 FDI Annual World Dental Congress held in Salvador da Bahia, Brazil. He will manage the FDI head office during the search for a permanent Executive Director.

Mr Estignard has been with the FDI since November 2009 as Finance & Operations Director. His prior experience includes five years as Senior Auditor at PriceWaterhouseCoopers in France and twelve years at SITA in France, Germany and Switzerland, including Head of Financial department at SITA, Switzerland, from 2004 to 2009.

Mr Estignard holds an MBA from International University in Geneva (Switzerland), a degree in Accounting and Finance from the ICS Business School in Paris (France) and a degree in Business Economics from the University de Sevres (France).

"Last month FDI hosted another Annual World Dental Congress in Salvador da Bahia, bringing together close to 5,000 participants worldwide. Striving towards better oral health never stops and we are now focusing on building a solid foundation for the work ahead of us. FDI is a membership organisation and as such, we are seeking to enhance services for our members, taking into account advices and opinions from all members, National Dental Associations and stakeholders.

I am privileged to attend that the FDI Elected have placed in me and am very enthusiastic about our future. With the support of the FDI Council, numerous volunteers, head-office staff and our partners, FDI is continuing its journey towards the vision of optimal oral health for all.

The FDI head office stays at your disposal and service. We welcome your questions and feedback, especially on the FDI’s new projects, launched at the recent FDI Congress in Salvador, such as Data Mirror and VOX. Both tools are developed with one goal—to better serve our members."

2010 FDI/Unilever Poster Award Competition

The six winners of the 2010 FDI/Unilever Poster Award Competition were announced during the VIP reception at the 2010 Annual World Dental Congress on 2 September. They are:

- Comparison of resin based sealants' ability to prevent cytotoxicity on cell lines MG-63 and Saos-2. Maryam Ehsani*, Ebrahim Zabihi (Iran)
- Prostaglandin-E2 induces receptor activation of the fusogenic factor kappa B ligand expression in human periodontal ligament cells via EP2 receptor. Nawapat Sakornwimon*, Auppreeru Rajachorntam, Prasit Parasuwan (Thailand)
- Prevalence/distribution of Porphyromonas gingivalis fimbriae subtypes in patients with severe periodontitis. Patrick Franke*, Sigurna Eich, Chong-ik van Kim, Peter Eckholz, Ti-Shan Kim (Germany)
- Activity of plant extracts from the Brazilian Pantanal against Streptococcus mutis. Fernanda Lourenço Brighenti, Mareos Jose Salvador, Alberto Carlos Botazzo Delhem, Adina Claudia Botazzo Delhem, Cristiane Yumi Koga-Do (Brazil)
- Locomotion in dental bacteria. Robert Boyd-Boland NLO Australian Dental Association
- Tooth loss and oral health self-perception of adults covered by health strategy for the family in Salvador, Bahia, Brazil. Mervea Sacramento dos Santos, Gama Melo Santos, Fabiana Nayral Florianio, Maria Isabel Pereira Vianna, Maria da Conceição Nascimento Costa (Brazil)
- Sickle cell disease, oral health status and socioeconomic conditions of children in the state of Rio de Janeiro, Brazil. Felipe Fagundes Souza, Thais Jerez Aranda Rossi, Maria Isabele Pereira Vianna, Maria Cristina Tristão Canguassu (Brazil)

More than 120 submissions were received by the FDI for the competition this year. The best posters were selected as finalists prior to the congress and they were then invited to present their posters and research to a panel of judges, followed by a question and answer session at the congress. All winners received a free registration to a future FDI Annual World Dental Congress and 1,500 towards his or her participation in the congress.

Information on the 2011 competition will be posted on the FDI website once it becomes available.
The FDI launched The Data Mirror, an interactive online mapping tool, at the World Dental Congress in Salvador da Bahia, Brazil.

The Data Mirror is an FDI online oral health database with a visualization engine that allows users to dynamically and visually interact with maps generated from up-to-date global oral health data. The Data Mirror presents data collected for The Oral Health Atlas in an interactive online format. The tool allows users to choose which information to display on the map and by allowing them to compare countries. The project led by the World Dental Development and Health Promotion Committee and was funded by a grant Johnson & Johnson.

FDI & Unilever Oral Care launch the second phase of their global partnership

The FDI World Dental Federation and Unilever Oral Care launched Phase II of their unique global partnership at the FDI Annual World Dental Congress, in Salvador da Bahia, Brazil.

The new partnership follows a successful five year first phase collaboration which saw 40 different health promotion programmes implemented in partnership between National Dental Associations (NDAs) and Unilever Oral Care brands in 57 countries.

Phase II of the partnership will again involve NDAs working in partnership with Unilever Oral Care locally, with a new goal to work together to measurably improve oral health through encouraging twice daily brushing with a fluoride toothpaste. With one goal aligning the partnership globally, it aims to have a greater and more measurable impact on oral health around the world. Projects will work through key influencers such as dentists, other health professionals and teachers, aiming to reach specific target beneficiaries of families, school children and infants, to educate them regarding the benefits of twice daily brushing with fluoride toothpaste and support them in taking up this fundamentally important oral health behaviour.

To mark the launch of Phase II, the partners held a Global Launch Workshop at the FDI Annual Dental Congress, attended by NDA representatives from participating countries and from the global partnership team at FDI and Unilever. Two members of the FDI World Dental Development and Health Promotion Committee, Professors Pratapchand Phantumesvan and Juan Carlos Llodra also gave presentations on the efficacy of twice daily brushing with fluoride toothpaste.

An outlook of the FDI AWDC 2011 in Mexico City

As organizers of the 2011 FDI Annual World Dental Congress, FDI and the Mexican Dental Association, in collaboration with the Mexican Dental Industry, are going all out to provide a memorable experience on all levels.

Hosted at the new, state-of-the-art Centro Banamex Convention Centre, participants will enjoy optimal conditions to participate in the scientific programme. This year’s theme “New Horizons in Oral Health Care” will explore the latest challenges and opportunities in the world of dentistry. In addition, the FDI World Dental Exhibition will showcase International and Mexican manufacturers and retailers, who will be exhibiting their latest products and services to FDI delegates.

The experience will be completed by opportunities for a full immersion into Mexican culture through optional tours, excursions and social events, as well as experience the welcoming Mexican hospitality, world-famous cuisine and rich cultural diversity.

Our official hotels are located in Polanco, one of the most dynamic areas of the city. In this neighbourhood you will be able to find the most sophisticated hotels, restaurants and the best shopping district. The main attraction of Polanco is being both residential and commercial, turn the area into a strategic business hub. Nevertheless it still has its original trendy atmosphere, great dinner options and at night it offers some of the best clubs in the city.

Please visit the International website www.fdiworlddental.org or the Regional website www.fdi2011.org for more information.

The Data Mirror

The FDI has created The Data Mirror so that the data from The Oral Health Atlas can benefit all health promotion and disease prevention public health projects including the FDI’s own, Live.Learn.Laugh., the World Dental Development Fund, the Global Carries Initiative and regional strategies. The data will also help to give clear advocacy and workforce projects. Moreover, the FDI and National Dental Associations (NDAs) will be able to better plan, implement and evaluate oral health projects by using this data. It’s expected that The Data Mirror will also help generate updated data for the second edition of The Oral Health Atlas.

Welcome to the new FDI members!

The General Assembly B in Salvador da Bahia has elected the following new members:

Regular
- Egypt – Egyptian Dental Association
- Belarus – Belorussian Dental Association

Supporting
- Academy of General Dentistry – AED
- Brazilian Academy of Dentistry – BAD

Vanuatu – South Pacific Smiles

About the publisher

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- **Extensively Researched:** Proven effective over a range of patient benefits in more than 60 well-controlled clinical studies with over 16,000 patients\(^5\).
- **Brushing with Colgate Total®** is more effective in reducing plaque and gingivitis than brushing with regular fluoride toothpaste\(^2\).\(^3\).


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Oral-Systemic Health: What is it?

Good oral health has taken a new meaning today. Studies have shown that diabetes and coronary heart disease have some association with gum disease (periodontitis).

Unfortunately, many periodontists (dentists who specialize in treatment of gum disease/condition) notice that gum disease is frequently disregarded by most patients since early disease cause little to no signs or symptoms.

Studies have shown that diabetics are more likely to suffer from periodontitis. Therefore, gum disease is known and acknowledged to be another potential complication of diabetes.

Recent research also suggests association between gum disease and coronary heart disease. Thus patients with untreated periodontitis may be exposed to increased risk of developing coronary heart disease.

What is Periodontitis?

In simple words, it is a chronic mixed bacterial infection of the tissues surrounding the tooth. The World Health Organization has shown that between 5-15% of the population suffer from severe periodontitis. But unfortunately, as opposed to tooth decay, the public has little knowledge or understanding about gum disease or periodontitis.

While dentists know that gum disease is a leading reason for tooth loss in adults aged 40 and above plus it is a ‘silent disease’, not causing pain until reaching the severe stage, yet many patients remain in the dark. As it is with diabetes and other medical conditions, it is important for everyone to be screened regularly so as to facilitate early detection. The diagnostic tool used to detect periodontitis is the simple basic periodontal examination and evaluation and dental X-rays.

Since early signs are easily missed, how can periodontitis be recognized, treated and kept under control? Apart from a little bleeding during brushing, accompanied sometimes with bad breath, itchy or vague uneasy feeling in the gums, there are no painful symptoms that could serve as an alarm. Therefore, it is important to consult the dentist to perform clinical tests with X-rays to check for the presence of gum disease.

The good news is that periodontitis can be treated and the best treatment results are obtained when it is detected at an early stage.

The 2nd piece of good news is that periodontal therapy can, through surgical procedures in some advanced cases, regenerate bone and gum tissue.

The final piece of good news is that with regular professional reviews and practice of good daily personal oral hygiene, with the help of an anti-bacterial and anti-inflammatory toothpaste/mouthrinse, periodontitis can be kept under control and recurrence can be minimized. Regular dental visits with good personal oral hygiene practice can help keep the mouth healthy and even help prevent other serious conditions from arising.
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Restoring missing mandibular incisors with implants

Mandibular incisors can be vulnerable to early loss due to their inherently weak periodontal support and high prevalence with respect to periodontal disease. What are the most common treatment options for missing mandibular incisors? Aside from removable prosthetic options, the restorative options for a fixed prosthesis include a conventional bridge, a resin-bonded bridge (Maryland Bridge) and implants. For a case in which one or two mandibular central incisors are missing, a threее- or four-unit bridge has often been the treatment of choice. A resin-bonded bridge, in these cases, can be a reasonable alternative to a conventional bridge; whereas implant treatment, more often than not, is not suitable due to insufficient space. When more than two incisors are missing, a three- or four-unit additional bridge; whereas implant treatment in the mandibular anterior region can be challenging due to:

1. insufficient facio-lingual bone volume;
2. insufficient mesio-distal space between adjacent teeth;
3. insufficient height of remaining alveolar bone;
4. the presence of mento-labial depression, which limits the facio-lingual angulation of implants; and
5. the preservation or recreation of the interdental papilla being an extremely delicate procedure.

One of the prerequisites for the successful placement of an implant is the presence of adequate bone volume. Tarnow et al. stated that a submerged implant, following the delivery of the prosthesis, will create circumferential or horizontal bone resorption of 1.5 to 1.4 mm. Grunder et al. also stated that at least 2 mm of alveolar bone must be present beyond the body of the implant to compensate for the effects of bone remodelling. If this amount of bone is not present, part or all of the facial or buccal bone plate will be lost after remodelling, with the subsequent risk of soft-tissue recession. This amount of bone around an implant rarely exists in the mandibular anterior region. Therefore, ridge augmentation procedures are often required to create adequate bone volume to maintain adequate implant thickness following implant placement.

Another prerequisite for successful implant treatment is sufficient interdental space. The creation of a natural-looking implant restoration largely depends on the appropriate placement of the implant during surgery. In order to achieve this goal, careful planning and precise implant placement are essential. An implant requires a minimum distance of 1.5 mm between the implant and adjacent tooth to maintain interproximal bone and interdental papilla. Standard-diameter implants of 4 mm or greater therefore require a mesio-distal space of at least 7 mm to place an implant. For an interdental papilla between two adjacent implants to be established, the interimplant distance should be more than 5 mm.

Thus, a minimum mesio-distal space of 14 mm is required to place two standard-diameter implants adjacent to each other. Implant manufacturers have introduced narrow-diameter implants (5.0 to 5.5 mm) in an attempt to solve these problems. However, these implants still require a minimum mesio-distal space of 6.0 to 6.5 mm to allow adequate implant-bone contact.

Fig. 1: Pre-op — Fig. 2: Pre-op X-ray — Fig. 3: Resin-bonded provisional restoration. — Fig. 4: Lingual view. — Fig. 5: Twelve weeks post-implantation.

Fig. 6: Following implant placement. — Fig. 7: Pre-op X-ray at implant insertion. — Fig. 8: Immediate provisionalisation. — Fig. 9: Modification of provisional restoration. — Fig. 10: Eight weeks post-implant placement.
Mimic-diameter implants (MDIs) are not synonymous with narrow-diameter implants. MDIs are smaller in diameter than narrow implants and have a diameter of 2.7 mm or less. Because of their smaller diameters, MDIs require minimal interradial space while preserving more of the alveolar bone following the ostotomies for implant placement. MDIs were initially developed to support transmucosal prostheses and were ultimately intended to be removed. However, these implants exhibited a bone-to-implant contact similar to that of implants with conventional diameters. Numerous studies have indicated that MDIs appear to be an effective treatment option for missing mandibular incisors. Nevertheless, one of the primary disadvantages of MDIs is the reduced resistance to occlusal loading. The retention of an implant, however, is correlated to the length of the implant and not the diameter. This implies that MDIs may be used in situations where excessive occlusal loading is not present.

MDIs of less than 3 mm in diameter are fundamentally challenged as two-piece designs due to the insufficient strength of their component parts. When the diameter of an implant approaches 5 mm or less, either the abutment screw becomes too small or the internal axial walls of the implant become too thin to withstand the function load. These concerns can be overcome with a one-piece design. One-piece implants have recently received substantial attention in implant dentistry; yet, one-piece implants are not new to implant dentistry. While the use of one-piece implants has been controversial, they have been used for decades with reasonable clinical success.

Recent variations from early designs have created a renewed interest in this old, but not obsolete concept. Most one-piece implants are composed of three portions—the bone-anchoring (fixation thread) portion, transmucosal portion and prosthetic abutment portion.

The primary disadvantage of one-piece implants is related to the fact that these implants must be placed with a one-stage protocol. Therefore, the angulation of the abutment cannot be altered and only minimal modification of the abutment is possible. Without the prosthetic freedom of the abutment choices, the initial surgical positioning of one-piece implants becomes critical in obtaining an optimal result.

The advantages of one-piece implants include minimally invasive surgery, simple restorative procedures and no screw loosening. Furthermore, the amount of crestal bone resorption may be minimised, since there is no microgap or micro-movement between the implant and its abutment. This becomes even more critical for long-term aesthetic results in the anterior region. In order to demonstrate the successful use of one-piece implants, this article describes the restoration of mandibular incisors with one-piece MDIs.

**Case reports**

**Case I**

A 22-year-old female patient presented with occasional throbbing pain in the mandibular anterior region. The patient’s medical history revealed a history of periapical lesions, delayed placement of implants was planned. The teeth were carefully luxated with a periosteum andatraumatically extracted, preserving the thin facial bone. A wire-embolished provisional restoration was fabricated and bonded to the adjacent canines with flowable resin (Figs. 5 & 6). After ten weeks of healing, the provisional restoration was removed. The distance measured between the two mandibular canines was 15 mm (Fig. 5).

A crestal incision was made and a limited soft-tissue flap was re- reflected to expose the alveolar crest of bone. In this fashion, the patient experienced reduced post-operative swelling and discomfort. With a 1.6 mm twist drill and copious irrigation, osteotomies were performed at a speed of 1,500 rpm. The angulation of the twist drill was carefully monitored throughout the osteotomies. Following completion of the prepared implant sites, visual and tactile inspection of the internal bony walls was performed to assure the absence of any microfissure or dehiscence at the cervical area. Two 2.5 mm-diameter implants (MDI) were then placed in the ideal 5:1 position and torqued to 25 Ncm with a manual torque wrench. The superior margin of the transmucosal portion was positioned 2 mm apical to the soft-tissue margin (Figs. 6a,b,c). Immediately following implant placement, provisional restorations were fabricated at chairside using prefabricated temporary abutments and acrylic resin.

The provisional restorations were trimmed in position using the friction-fit temporary abutments, eliminating the use of
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Cement (Figs. 8 & 9). This could remove the risk of cement being forced into the gap between the implant fixture and soft tissue. The provisional restorations had no centric or eccentric occlusal contacts. The patient was instructed to avoid any function of the implant for eight weeks. After a healing phase of two months, a final impression was produced using friction-fit impression caps (Figs. 10 & 11). Definitive restorations were then fabricated on the working cast and adjusted to have slight occlusal contacts in centric occlusion and excursive movements (Figs. 12-14). The clinical re-evaluation demonstrated a minimal gingival change around the prosthesis, and a stable horizontal bone level was observed radiographically at the 15-month follow-up (Figs. 15 & 16).

Case II
A 56-year-old male patient presented with severe mobility and peri-apical lesions on teeth #23 and 24 (Fig. 17). A provisional restoration was fabricated and bonded to the adjacent natural teeth immediately following extraction (Fig. 18). The provisional restoration was left undisturbed for 11 weeks and the interdental papillae were preserved with ovate pontics (Figs. 19 & 20).

The interdental distance measured between teeth #22 and 25 was 8 mm, and two 2.5 mm-diameter implants were placed in position. The superior margin of the transmucosal portion was positioned sub-gingivally, and the height of the abutments was reduced to ensure adequate initial clearance (Fig. 21). Owing to the limited interdental space, the impression caps were modified (Fig. 22). An indexing jig was used to avoid any undue stress applied to implant fixtures during the impression procedure (Fig. 23). An altered cast was made, and a definitive prosthesis was fabricated. The clinical and radiographic evaluation at 11 months demonstrated a good aesthetic result with no significant peri-implant bone loss (Fig. 24).

Conclusion
Based on the clinical cases presented in this article, the utilisation of one-piece MDIs appears to be a good treatment option for replacing missing mandibular incisors. Considering the simplicity, ease of implant placement and immediate provisionalisation, this treatment offers a new option for patient care.

Contact Info
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The new composite IPS Empress Direct (Ivoclar Vivadent) enables us to create restorations that are almost invisible to the human eye. The appropriate increment technique together with correct handling of the materials and high-gloss polishing produces predictable, aesthetic results directly in the mouth. Owing to its nano-hybrid structure, the material can also be used to restore posterior teeth. IPS Empress Direct materials are available in various levels of opacity, translucency and brightness. By combining the different materials, toothlike light scattering can be achieved. The working steps of the technique used to place IPS Empress Direct are described in this article.

Clinical case: Step-by-step restorative procedure

A young patient presented with a defective resin composite filling in tooth #11. The margin was no longer tight and the interface between the tooth structure and the restoration exhibited staining. What is more, the chroma, opalescence and shade of the filling did not correspond to that of the natural dentition (Fig. 1).

According to the treatment plan, the filling would be removed, the cavity prepared along minimally invasive principles and the tooth restored with a direct resin composite. In order to achieve impeccable integration of the restoration in the oral environment and an aesthetic smile line with a uniform colour, the composite would have to be placed using the increment technique. As the cavity had walls on all sides, there was no need to create a wax-up or a silicone template to restore the tooth shape. A layering scheme was established before the treatment was begun.

During the dental examination, the general preoperative situation, the natural colour of the patient's teeth and individual characteristics were photographically documented. The layering scheme was prepared on the basis of the photographs. The different materials that would be used for the restoration were established in the process. In order to reproduce the special characteristics of the patient's tooth anatomy, the appropriate dentine and enamel shades were selected along with an opalescent material and a white-opaque material (from the IPS Empress Direct range).

At a second appointment, the operating field was isolated with a rubber dam, since absolute moisture control is indispensable in the placement of resin composites (Fig. 2). The outer margins of the old filling were traced with a pencil. This was done to highlight the transition between the filling and the tooth structure in the removal of the old filling. A small chamfer was prepared on the vestibular side, as this is indicated for this type of restoration (Fig. 3). Next, the enamel and dentine were etched with 37 % phosphoric acid (Total Etch) and a three-component adhesive (Syntac) was applied (Figs. 4 & 5).

In order to obtain the desired tooth shade, the dentine part of the restoration was built up first with dentine material (IPS Empress Direct Dentin A2; Fig. 6). A translucent and opalescent material (Trans Opal from the IPS Empress Direct range) was placed over the entire facial surface of the restoration to cover all the previously placed materials (Fig. 8). At a second appointment, the restoration was polished to a high gloss finish using aluminium oxide, diamond burs at low speed. This allowed the procedure to be precisely controlled. A three-step silicate polishing system (Astones) was used to finish and polish the restoration. Finally, the restoration was polished to a high gloss finish using aluminium oxide, diamond pastes (Shiny System, Microem), brushes and felt wheels.

It is worthwhile recalling the patient for a third appointment to ensure that the restoration blends into the natural environment when the tooth is moist and to establish whether any shape or colour adjustments need to be made (Fig. 9).

Dr Anna Salat Vendrell is practising as an aesthetic dentist in Barcelona in Spain. She can be contacted at annusalat@hotmail.com.
Case acceptance in complex-care dentistry

Dr Paul Homoly

I see patients who, in essence, are just like the estate agents I know in a real estate office. They go to a real estate agent, would you believe it, to purchase a new house. You go to a real estate agent, and you settle on the broad outside-the-mouth issues—like the suitability conversations—before you have any idea of what you can afford. That makes the difference between cement versus gravel space foundations and vinyl siding versus brick exteriors. She goes as far as to recommend another appointment with her so she can show you how clean your house clean before you buy one. She does all this before she has any idea of what you can afford.

The inside-out versus outside-in approach. The earlier influencers in my dental career emphasised that a significant part of being a good dentist is to get patients to change. Change the way they clean their teeth, change what they eat and see the priorities in their life and put dental health at the top. It took me ten years and thousands of patients to realise that patients change when they are ready, not when I tell them to.

I learned to replace the concept of change with the concept of fit. Instead of telling patients they need to change to accommodate my treatment plan, I learned to accommodate my treatment plan to fit their life situation. Patients, especially the ones with complex-care patients, have complex fit issues. These include finances, family hassles, work schedules, special current events, travel stressors, health factors, significant emotional issues; in short, any issues dominating the patient’s energy and attention. When you present complex-care dentistry, it has to fit into the patient’s life.

Think about it. If you offer most patients a US$10,000 treatment plan, something in their life has to happen. People need to wait to receive their tax refund, wait for a child to graduate from college, become...
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11:20 - 12:20 Allen Pucci, DDS
LIGHT CURED ADHESIVE DENTISTRY - SCIENCE AND SUBSTANCE - COURSE: 3030
1:20 - 2:20 Martin Goldstein, DMD
A SIMPLIFIED APPROACH TO MULTI-LAYER DIRECT COMPOSITE BONDING - COURSE: 3040
2:40 - 3:40 Jay Repnick, DMD, MD
3D IMAGING AND CT-GUIDED DENTAL IMPLANT SURGERY - 3050
4:00 - 5:00 Ilan Malachser, DDS, MAGD
TOTAL FACIAL ESTHETICS FOR EVERY DENTAL PRACTICE - COURSE: 3060

MONDAY, NOVEMBER 29
10:00 - 11:00 Mt. Nosel Ream-Beekley
ECO-FRIENDLY INFECTION CONTROL UNDERSTANDING THE BALANCE - COURSE: 4120
11:20 - 12:20 Gregory Kurzman, DDS
INTEGRATING NEW ADVANCES IN DENTAL MATERIALS AND TECHNIQUES INTO YOUR RESTORATIVE PRACTICE - COURSE: 4130
1:20 - 2:20 Damien McManus, DDS
OPTIMIZING YOUR PRACTICE WITH 3D BEAM TECHNOLOGY - COURSE: 4140
2:40 - 3:40 Edward Katz, DDS
IMPROVING PATIENT CARE WITH 3D CORE BEAM COMPUTERIZED TOMOGRAPHY - COURSE: 4150
4:00 - 5:00 George Freedman, Fay Goldstep and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 4160

TUESDAY, NOVEMBER 30
10:00 - 11:00 George Freedman, Fay Goldstep and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 3110
11:20 - 12:20 Greg Diamond, DDS
LASERS IN PERIODONTAL THERAPY - COURSE: 5120
1:20 - 2:20 Ov Almog, DMD
INTRODUCTION TO CORE BEAM CT (CBCT), ESPECIALLY AS IT PERTAINS TO PREVENTION OF FAILURES IN ORAL IMPLANTOLOGY - COURSE: 5130
2:30 - 3:30 Maria Ryan, DDS, PhD
DETECTING CORONARY HEART THROUGH PERIODONTITIS AND PERIMPLANTITIS - COURSE: 5140
4:00 - 5:00 Dwayne Akechibua, DDS
CONTEMPORARY CONCEPTS IN TOOTH REPLACEMENT: PARADIGM SHIFT - COURSE: 5150

WEDNESDAY, DECEMBER 1
12:00 - 1:00 Mr. Al Duke
BEST MANAGEMENT PRACTICE, WASTE MANAGEMENT FOR THE DENTAL OFFICE, AND ORAL COMPLIANCE - COURSE: 6060
1:20 - 2:20 Glenn van As, DDS
HARD AND SOFT TISSUE LASERS - COURSE: 6070
2:45 - 4:15 Dr. Shnidel Beshara, Dr. David Haasler, Dr. Jeffrey Haas, Dr. Dwayne Kameaha, Dr. Eric Randles
THE FIRST ANNUAL GUYSDENT UNIVERSITY SUMMIT: IMPLANT DRIVEN DENTISTRY - COURSE: 6060

THIS PROGRAM IS SUBJECT TO CHANGE.
Discovering fit issues
Your team often knows what is going on in the patient’s life. How do they know? They talk—they chat—chat with the patients and they make friends. Another purpose of chat—chat is to learn about those fit issues in your patient’s life impacting their treatment decision. When chat—chat is intentional, I call it fit-chat—an indirect way of discovering patient fit issues.

When you fit-chat, be curious and listen more than you talk. Listen to the manner in which patients spend their time and what is important to them in their life—health, money and/or family issues. If they mention something you believe may influence a treatment decision, be curious, listen attentively and encourage them to talk more about it. Through indirect fit-chat, you’re going to discover what’s going on in patients’ lives.

Some patients do not fit-chat well. They are simply not talkers. I am that way. When I get my hair cut, the last thing I want is to talk—a disconnected style (do not speak too quickly, do not look the patient in the eye, maintain a conversational tone of voice and be relaxed). Be sure to pause long enough to let what you are saying sink in.

If you attempt to use a direct approach to fit issues but have a disconnected style (do not look the patient in the eye, speak too quickly, do not listen attentively), your conversation may be perceived as being inappropriate, unprofessional and seeking to diagnose their pocketbook status.

Advocacy
Advocacy is the experience of patients when they realise that you are guiding them towards and not selling them into an absolute prerequisite to a successful treatment plan is for you to have a connected communication style. This means you hold good eye contact, listen carefully and patiently; you maintain a conversational tone of voice and when your speaking rate is relaxed. Be sure to pause long enough to let what you are saying sink in.

I know I can help. What do I not know is whether this is the right time for you. You mentioned you travel a lot and your company is in the middle of a big re-organisation. Do you go ahead with your treatment now? Do we wait until later? Or do we do it over time? Help me understand how I can best fit your treatment into everything that is going on in your life."

This advocacy statement leads to a conversation about the patient’s fit issues. This conversation reveals what treatment fits and what does not. You will find that this approach results in many complex-care patients doing their treatment over time, allowing them to stay within the limitations of their fit issues. This is a good thing. I would rather treat two patients for US$5,000 each than no patients for US$10,000. It also yields lifetime patients for you. Patients will exhibit fierce loyalty to you when they experience advocacy.

The decision to educate
The decision when to educate and when to advocate is situational. Figure 5 demonstrates that the impact of patient education on case acceptance is highest when the complexity of the care (and its associated fee) is minimal. Patient education is the driver of case acceptance when a patient’s conditions and fees are minimal. However, when the complexity of care increases, the role of advocacy takes over. Advocacy is the driver of case acceptance when the patient’s conditions are complex and fees are high.

Copy Figure 5 and keep it in area where you will see if often. Then, right before you go into case presentation, look at it and ask yourself: does this patient need education or advocacy? Let the situation guide you. When you do, you will discover how to keep from educating your patients out the door.

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Contact Info

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Copy Figure 3 and keep it in

“...As you live and travel quite a bit. I also know you are aggravated by food trapping around your lower partial denture. Let’s talk about your choices and how we can best fit your dentistry into what is going on in your life. Is now a good time to talk about this?”

Here is another example of a direct approach: “Kevin, most people like you are busy, on-the-go and have lots of irons in the fire. I know if any of these irons are affecting the amount of stress you are under, the amount of time you can spend here with us, or if there are financial issues I need to consider when planning your care. I want to reassure you that dental health is to be an advocate. To guide patients into complex care effectively you need to take the fit circumstances of their life into account.”

Here is another example of a direct approach: “Kevin, most people like you are busy, on-the-go and have lots of irons in the fire. I know if any of these irons are affecting the amount of stress you are under, the amount of time you can spend here with us, or if there are financial issues I need to consider when planning your care. I want to reassure you that...”

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Prof Nasser Barghi, W.D.C. and Head of Dentistry - Aesthetic Dentistry, University of Texas, San Antonio, USA

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