First vaccine for treating gum disease

Daniel Zimmermann

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A new vaccine could help to replace traditional periodontal treatment methods. (DTI/Photo Dmitry Naumov)

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“Periodontitis is a serious disease and dentists face a major challenge in treating it, because most people will not know they have the disease until it’s too late and the infection has progressed to advanced stages,” says Prof. Eric Reynolds, CEO of the Cooperative Research Centre for Oral Health Science and the Head of the University of Melbourne’s Dental School. “This new approach will provide dentists and patients with a specific treatment.”

Traditional periodontal therapy involves manual scaling and cleaning, and even surgery with instruments or dental lasers in an effort to contain the bacterial infection. Reynolds said their new line of vaccine products will possibly prevent the progression of the disease, rather than managing its symptoms and damaging consequences.

Sanofi Pasteur has an option to an exclusive worldwide licence to commercialise the intellectual property associated with these products.

A new treatment protocol is targeting the ‘ring leader’ of gum disease until it’s too late and the infection has progressed to advanced stages,” says Prof. Eric Reynolds, CEO of the Cooperative Research Centre for Oral Health Science and the Head of the University of Melbourne’s Dental School. “This new approach will provide dentists and patients with a specific treatment.”

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Asia News

Countries in Asia less than average in health care spending

Daniel Zimmermann

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

The US currently spends more on health care than any other country – almost two and a half times greater than the OECD average. One-third of the OECD average. (DTI/Photo Sean Prior)

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

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

Malaysians reject public dental services

Claudia Salwiczek

HONG KONG/LEIPZIG, Germany: Kuala Lumpur’s Deputy Director of Health Dr Ahmad Bujang has urged Malaysians to have their teeth checked once or twice a year and children at least every six months, despite the present problems in government dental services. Given the current dental status of Malaysians, dental checks are important, as early detection of dental diseases like caries or gingivitis allows for more effective treatment, he said.

The Ministry of Health of Malaysia expects half of Malaysian adults in the country use government dental services. In the long run, the government aims to achieve the projected target ratio of 1:4,000 dentists to the population is only 1:15,245, while the ratio for both private and public dentists combined is 1:7,941. This leaves patients to wait for long periods for treatment, as public dental clinics operate according to appointments.

Dr Bujang was responding to a statement released by the Ministry of Health in November claiming that only 6 per cent of adults in the country use government dental services. Public dentistry in Malaysia falls short compared to other countries in the region, especially in rural areas, where only 60 per cent of dental officer posts are filled. According to latest government figures, the current ratio of public dentists to the population is only 1:15,245, while the ratio for...
Asia will assure future growth, 5M’s Buckley says

Daniel Zimmermann

NEW YORK, NY, USA/LEIPZIG, Germany: George Buckley, Chief Executive Officer of 3M, has announced that his company intends to take advantage of more overseas opportunities in regions like Asia Pacific in the coming business year. Speaking to investors in New York in early December, he said that he expects revenues to grow by 11 to 15 per cent in emerging markets like China and India. Owing to the worst economic downturn in 80 years, the company’s US sales suffered significantly this year.

Despite the outlook of a slow economic recovery, Buckley outlined his company’s ongoing commitment to investing in its core businesses while continuing to focus on cash generation in light of the still uncertain global economy. 3M, with US headquarters in St Paul in Minnesota, offers a wide array of dental products through its division 5M ESPE, including adhesives, dental cements and products for restorative and aesthetic dentistry.

According to latest estimates, 3M sales are expected to reach between US$24.5 and US$25.5 billion in 2009, with organic sales volumes growing by 5 to 7 per cent and currency effects adding 2 to 3 per cent to sales for the year. The company also expects that 2010 earnings will be between US$4.85 and US$5.00 per share, a slight increase compared to 2009.

Waiting lists in dental clinics trouble S’pore

Daniel Zimmermann

HONG KONG/LEIPZIG, Germany: Representatives of the Ministry of Health and the National Dental Centre (NDC) in Singapore have rejected criticism about long waiting lists for special dental procedures in government dental clinics. In a public letter posted on the Singapore Dental Association’s website in December, Dr Kwa Chong Teck, Executive Director of the National Dental Centre, and Chief Dental Officer Patrick Tyring said that for patients seeking elective specialist treatment, the NDC generally offers an appointment within two weeks. They admitted, however, that there is a waiting list of patients requiring elective crown and bridge work, root canal treatment or dentures.

In Singapore, special dental treatments are subsidised only when patients are referred from government dental clinics. The national medical saving scheme, called Medisave, which is supposed to help individuals set aside part of their income to meet future personal or immediate family’s hospitalisation, only covers one-day surgical procedures.

The Ministry of Health has rejected demands to extend the scheme for private clinics to reduce waiting times. Recent feedback on delayed procedures came from patients asking for non-emergency elective treatments, such as braces and dentures, a government official said. She added that heavy subsidy without means-testing for these procedures would inevitably lead to long queues.

“Medisave should be treated as a financial reserve so that treatment needs are met,” Dr Anagar Cheng, a consultant dental surgeon at a private dental clinic in Singapore, told Dental Tribune Asia Pacific. “The key is to identify those dental treatments that should be regarded as needs versus the non-urgent optional treatments like tooth whitening, which should be taken out of the equation. There is no doubt that governmental clinics will be able to cope with the public demand with time.”

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Agreements

China: Ivoclar Vivadent Marketing Ltd (Shanghai) has signed an exclusive distribution agreement with SS Dental (Shanghai) for its products and services in the Chinese market. The agreement covers all products and services of Ivoclar Vivadent.

India: Ivoclar Vivadent Marketing Ltd (India) has appointed its new distributor in the southern region of India to handle its products and services. The distributor, Universal, will take responsibility for the southern region, encompassing Kerala, Tamil Nadu, Karnataka, Andhra Pradesh and Puducherry.

Singapore: Ivoclar Vivadent (Singapore) has expanded its distribution network in Singapore by appointing an exclusive distributor to handle its products and services. The distributor, Neerbishane, will take responsibility for the specialist market.

The market in Singapore is expected to grow by 5 to 7 per cent in 2010. The country has a high percentage of employed individuals who set aside part of their income in Medisave, a national medical saving scheme, which is supposed to help individuals set aside part of their income to meet future personal or immediate family’s hospitalisation.

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www.ivoclarvivadent.com

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We wish all our readers a successful new year 2010...
Rice University to work on oral cancer test

Daniel Zimmermann

NEW YORK, NY, USA/LEIPZIG, Germany: Researchers at the Rice University to work in the US have received a US$2 million grant from the US National Institutes of Health for the development of a new test for detecting oral cancer. The test, which utilises latest LED and nano microchip technology, aims to provide an accurate diagnosis in less than 50 minutes and can be performed in the dental office. Additional tests for the detection of cardiovascular diseases and HIV are also in development, the researchers said.

Oral cancer affects about 500,000 people per year worldwide, and most cases are diagnosed in the late stages. If oral cancer is detected early, the prognosis for patients is excellent, with a five-year survival rate of more than 90 per cent. Unfortunately, the actual five-year survival rate for oral squamous cell carcinoma is only about 50 per cent, amongst the lowest rates for all major cancers.

“We want to provide an accurate diagnosis for oral cancer using a minimally invasive test that requires no scalpels or off-site lab tests,” said principal investigator Prof. John McDevitt, Rice’s Brown-Wiess Professor of Chemistry and Bioengineering. “The payoff for this could be tremendous because oral cancers today are typically diagnosed much too late in their development.”

According to McDevitt, the test is being developed in collaboration with other scientists from universities in the US and the UK.

THE BUSINESS OF DENTISTRY

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To the Editor

Re: Editorial, (Dental Tribune Asia Pacific No. 17, Vol. 7, page 1)

In the UK at least the number of female graduates in dentistry has outnumbered male graduates for some time. In terms of new graduates there is certainly no longer a problem with the gender balance. The problem with the well-known opinion leaders is partly that they are further through their career, therefore many of them graduated at a time when more men were graduating than women. What is more of a long term problem is that in order to be a well-known opinion leader in dentistry you need to devote an enormous number of hours to a combination of higher training, attending and lecturing at courses all over the world, usually in addition to running a practice. This pretty much incompatible with the home life of many women who want to be able to have children who are raised with lots of parental input. Until society changes so that fathers feel both more willing, and able to take a part in flexible and part time working, and spend more time in the home, most women will sacrifice career glory for the emotional needs of their children. We need changes in all professions and industries so that men who want to can take on more childcare responsibilities, and allow their female partners to be leaders in their professions, where they want to be, without being forced to put their children into long hours of childcare.

Lucy Nicholls, UK, 12 Dec. 2009

Re: “Experts discuss future of implantology in Gothenburg”, (Dental Tribune Asia Pacific No. 10, Vol. 7, page 1)

This is exactly what I have been thinking. We are pricing ourselves out of the dental implant market. What good is the invention, innovation or treatment when only the elite population can afford it? The concept of treating the patient with only a small number of implants is not correct. We need to replace all missing roots with implants, rather than performing different ways of unproven restoration for the sake of cost.

Norman Kwan, Canada, 6 Dec. 2009
New York, NY, USA/Leipzig, Germany: The US-based manufacturer of soft-tissue dental lasers AMD LASERS has announced the launch of its new International Center for Laser Education (ICLE) in Indianapolis in the US. The centre, which is headed by laser expert Dr Glenn van As, will offer education for the most popular lasers in dentistry through video, hands-on courses, and an interactive laser forum. ICLE claims to be the first laser company to offer affordable laser education to dentists worldwide.

Several variants of dental lasers are already in use, with the most common being diode lasers, carbon dioxide lasers, and yttrium aluminium garnet lasers. Latest studies have proven that laser applications for dentistry range from surgery to cosmetic procedures and even treatment of periodontal and peri-implantitis infections. The cost of a dental laser is between US$8,000 and US$50,000.

“Until now, most laser courses have been expensive and not specific enough in content to really assist dentists in understanding the safety, efficacy, and proper use of dental laser technology,” said Dr van As. “Just as AMD LASERS has made cutting-edge laser dentistry a reality for dentists, ICLE intends to revolutionise laser dental education through courses of unprecedented quality, accessibility, and affordability.”

According to Dr van As, ICLE’s courses will be suitable for both experienced clinicians and dentists new to laser dentistry. The forum will allow dentists to ask questions, post technique videos, and share laser experiences, he added.

Researchers at the University of North Carolina (UNC) in Chapel Hill in the US have discovered that almost one third of all human genes is involved in the inflammation of gingival tissue. By observing gum samples at molecular level collected from fourteen individuals with mild gingivitis, they found that more than 9,000 genes are expressed differently during the onset and healing process of the condition. According to the latest figures of the International Human Genome Sequencing Consortium, the estimated number of genes in the human body ranges from 25,000 to 30,000.

The study, supported by the US National Institutes of Health and oral health-care manufacturer Procter & Gamble, is the first to identify gene expression and the biological pathways involved in the onset and healing process of the condition. According to latest figures of the International Human Genome Sequencing Consortium, the estimated number of genes in the human body ranges from 25,000 to 30,000.

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Directa presents new solutions for Class II cavity preparations

Daniel Zimmermann

LEIPZIG, Germany: Placing a matrix band to attain a good contact point and avoiding interproximal overhang after excavation for Class II fillings has always been a time consuming and laborious procedure. Directa has announced to offer a unique and easy solution for this procedure by combining a separating plastic wedge with a stainless steel matrix. The Fendermate is available in regular and narrow width and for left or right application and will be colour coded for better identification. According to the Swedish company, the combined matrix and wedge are inserted as one piece. A new technology contours and compliments the curvature of the patients tooth and holds its shape without having to use a retentive ring that inhibits access to a cavity. The contact point is created by the dual curvature of Fendermate so that further furnishing will not be necessary. With the combination of FenderMate and FenderWedge, Directa also offers a tissue friendly approach for the preparation and filling of Class II cavities.

US dentist develops Face Lift Dentistry

PR Newswire

After 30 years of cosmetic and bite reconstruction dentistry in Los Angeles, Beverly Hills and Santa Monica, Dr. Sam Muslin has perfected and trademarked Face Lift Dentistry, an advanced procedure to ensure lasting results in health, comfort and appearance. Non-surgical, it is supposed to optimise dental health and idealise the bite to augment the specific facial features of the patient. Dental patients can look ten years younger just from work on the teeth that lengthens and supports the face, Dr. Muslin says. As a person ages, teeth become worn down and uneven due to wear and tear and different kinds of dental work in the mouth. Patients who have short faces, narrow cheeks, aging lips, and facial wrinkles usually have worn down teeth and a form of bite collapse. Because the tooth wear is gradual, the person usually does not realise how much deterioration has occurred.

“The teeth are the foundation of the face, but most doctors do not understand how much the teeth can enhance the facial features,” says Dr. Muslin, who is a Master of the US Academy of General Dentistry. “Cosmetic face lifts and cosmetic dentistry often cannot produce optimal results for the patient.”

According to Dr. Muslin, the Dental Face Lift is done with a high level of coordination and efficiency. During the first appointment, poor crowns, loose teeth, gum disease, bad bite and facial collapse are taken care of and the patient receives temporary crowns, veneers and fillings. On the second visit, all of the new crowns, porcelain veneers and fillings are bonded to achieve a complete reversal of bite collapse, permanent facial support and lengthening of the patient’s face, Dr. Muslin says.

“Face Lift Dentistry goes beyond cosmetic dentistry and cosmetic surgery to completely treat both health and facial appearance. Either alone or combined with a surgical face lift, it will achieve superior results,” he adds.

(Edited by Daniel Zimmermann)
The unprecedented success of Dental Salon Chile

Javier Martínez de Pisón
DT Hispanic and Latin America

SANTIAGO DE CHILE, Chile: The sixth annual edition of Dental Salon Chile has nothing to envy from the best Asian, American or European expos in terms of quality and professionalism. Lodged now for the first time in the modern fairgrounds of the Espacio Riesco, the Dental Salon offers ample quarters, modern facilities and many comforts to the visitor. But probably the most surprising feature is the high quality design of spaces, isles and booths, an influence that expo organizer Miguel Wechsler says he has assimilated from attending shows such as IDS in Germany and GNYDM in New York.

Wechsler has radically changed the look and feel of Dental Salon Chile, which until 2008 took place in cramped grounds. The Espacio Riesco by comparison, ten minutes away by car from downtown Santiago and for which Wechsler now provides free buses every 15 minutes, is a large concrete structure from which huge, colourful billboard-size banners promoting the Salon hung outside welcoming the visitor.

The Chilean businessman says that he has invested a lot of time and resources in organising this 2009 Salon, but that the projected growth statistics for the dental industry in Chile support his effort. Chile is actually a small country, but has developed a quality infrastructure, and its economy is one of the most prosperous in all of Latin America. Wechsler says that the dental market in Chile is growing between 20 and 30 per cent per year.

Chilean dentists and researchers are renowned in Latin America as high-standard professionals, with a tendency to buy expensive, high-quality American and European instruments, products and equipment, which is not the case with other colleagues in the region. It is estimated that there are over 11,000 practicing dentists in the country today, a number that increases by 12 per cent every year.

Wechsler says that the 2010 Dental Salon will have an international German Pavilion, and that he’s in negotiations with the Swiss industry for the same purpose. At the IDS in Germany he was talking with representatives of the American Pavilion, who are also interested in the Chilean market.

Actually, the director of the Dental Salon is so confident in the Chilean market that he is exploring the possibility of organising expos in Peru, Bolivia, Paraguay and Argentina.

“We when the international industry sees the quality of this Dental Salon Chile they are happily surprised,” Wechsler says. “Because they recognise that it has been modelled after successful American and European expos. They recognise that it is a highly organised and professional effort, and many ask me if I would consider doing something similar in other countries of the region.”


Fig. 1: Miguel Wechsler—Fig. 2: The Chilean dental market is growing at an annual rate of 12 per cent. (DT/Photos Javier Martínez de Pisón)
Message from the president

In September I was bestowed the great privilege—and responsibility—of representing the international voice of dentistry, as its elected leader. Throughout the last few months, I have met FDI members and delegates at their national and regional events around the world, such as the Annual Meeting of the Portuguese Dental Association and International Association for Dental Research (IADR) World Congress on Preventive Dentistry. In doing so, I am struck by the vast reach of this great organisation. Whether it’s collaborating with bilateral Council and Committee volunteers on the many FDI projects in development, participating in important international governmental meetings, or spending time with staff at the head office to better understand the day-to-day workings of the organisation, I am continually impressed with how each one of FDI’s many parts contributes to our achievements as a whole.

One of the questions I am asked repeatedly when meeting people for the first time is Dr Roberto Vianna, FDI President—as opposed to Dr Roberto Vianna the dentist, professor, dean or entrepreneur—on his time during this upcoming two-year term. My answer to this question is that my vision for the FDI to be is to true to the FDI vision: bringing together the world of dentistry, representing the dental profession of the world, and stimulating and facilitating the exchange of information across all borders with the aim of optimal oral health for all people. The FDI vision is a collective one, developed by and for our members, and should serve as the guiding light to our representatives, elected delegates, partners and supporters, and individual volunteers who dedicate that time and energy to advancing the profession, scientifically, educationally or socially.

Volunteer commitment is an essential component of a strong FDI. I hope you will join me in recognising the contribution of long-standing FDI volunteer, Dr Peter Swiss. Dr Swiss will be “retiring” from the FDI next year, after more than 40 years of tireless service in a variety of roles across the organisation. His spirit of giving time through voluntarism is an example for others to follow. His work is greatly appreciated and will be missed. And as we say thank you to Dr Swiss and reflect on the year he has dedicated to FDI, we welcome seven new and one returning member(s): Barbados Dental Association, Association Burundaise des Chirurgiens-Dentistes, Sociedad Dental de El Salvador, European Federation of Orthodontics, European Dental Students’ Association, National Children’s Oral Health Foundation, and the Guam Dental Society. This month we take a closer look at the European Dental Students’ Association: the eagerness of this group of dental students to get involved in volunteer and advocacy activities related to oral health promotion promises a bright future for dentistry.

As the sum of many diverse parts, FDI is only as strong as its relationships and in this respect, I hope that our service as FDI President can help strengthen existing bonds and build new bridges for the organisation. Such bridges might come through increased cross-Council collaboration, external partnerships with neighbouring Geneva-based NGOs dedicated to health promotion, or a forum for intra-member communication and exchange. In November, FDI took part in a significant meeting co-hosted by the World Health Organization and United Nations Environmental Programme and participated in the 2009 Greater New York Dental Meeting, with a progressive continuing education programme entitled, Dental Caries: Can the Paradigm of Care Shift?

Looking ahead to 2010 there are many exciting opportunities on the horizon, starting with our own FDI website. Invite you to watch for the new front page and user-friendly knowledge coming this January. Then in February the FDI Committees will convene for mid-year meetings at our beautiful head office in Geneva. In the meantime, my warmest wishes to you and your loved ones for a happy and fulfilling New Year.

Dr Roberto Vianna
FDI President

FDI participates at WHO/ UNEP meeting on future use of materials for dental restoration

FDI World Dental Federation participated in a joint meeting of the World Health Organization (WHO) and United Nations Environmental Programme (UNEP) on 16-17 November, 2009 in Geneva, Switzerland. Experts from around the world were invited to the meeting to assess the scientific evidence available on the use of restorative materials, including dental amalgam, and the implications of using alternatives to amalgam in dental restorative care.

FDI President, Dr Roberto Vianna, and Executive Director, Dr David Alexander, attended the meeting, presenting a unified position on dentistry based on the resolution on amalgam drafted and passed at General Assembly during the 2009 FDI Annual World Dental Congress (AWDC) in Singapore. In a presentation entitled “Dental restorative materials in clinical practice versus the dental profession”, Drs Vianna and Alexander argued that no ban or phase-down of mercury used in the dental profession should occur before a true alternative to dental amalgam is widely available in all communities. This FDI position is based upon several FDI-Sic Berries bridges that were universalized in research projects and was jointly crafted under the leadership of the Science Committee.

FDI has been closely monitoring developments with regards to the global regulation of mercury as a member of the FDI Global Mercury Partnership. Following the 2009 FDI AWDC, the Science Committee recommended the formation of a task team to ensure the international dental community, and issues regarding dental amalgam, were universally represented in UNEP discussions. This task team includes Dr Eduardo Cecotti (CMSC), Dr Peter Coursay (WDI), Dr Stuart Johnston (DPC), Dr Derek Jones (SCC), Prof Masaki Kambara (Council), Dr Orlando Monteiro da Silva (ExecC), Dr Sarkis Sozkes (EduC) and Dr Martin Tsai (consulting expert). Dr Johnston was at the FDI head office in Geneva during the WHO-UNEP proceedings to represent dental practitioners and provide leadership in the preparation of an official FDI Statement of Position.

The recent WHO-UNEP meeting is part of a two-phase approach designed to inform future intergovernmental discussions on the subject. Other meeting attended included Professor David Williams, President of the International Association for Dental Research (IADR), Dr Daniel Meyer, Senior Vice-President, Science/Professional Affairs at the American Dental Association (ADA), and Dr Benoit Soucy, Director of Clinical and Scientific Affairs at the Canadian Dental Association (CDA).

More information about the UNEP Global Mercury Partnership and FDI’s official Statement of Position following the WHO-UNEP meeting in Geneva is available at the FDI website (www.fdiworlddental.org).
FDI website undergoes “makeover”

The FDI website (www.fdiworldental.org) will have a new look beginning January 2010, featuring a simplified navigation structure and menu tabs so that FDI’s members and partners can access relevant information about the organisation’s history, structure, projects, activities, and Annual World Dental Congress more easily, and in fewer clicks.

Some features of the new FDI front page will include:
• Direct links to current FDI projects and activities
• Quick Links to the members section, latest news stories, FDI publications and a sign-up form for the Worldental Communique
• A role for front page menu (to simplify website navigation)
• Expanded Congress & Events section, including a section to highlight FDI members’ events
• Media section, with a direct link to press releases, archives and press contact information
• Improved Search functionality
• Contact Us tab in the front page menu with FDI’s address and phone number in Geneva

For more information, contact the FDI at media@fdiworldental.org.

FDI staff at head office in Geneva

The FDI saw some significant changes at the head office in 2009 and as we settle into our new home in Geneva, Switzerland, FDI is now entering a new phase in the organisation’s history.

The relocation from Ferney-Voltaire (France) to Geneva ran smoothly thanks to the notable efforts of FDI staff and in particular, Ms. Laurence Joulie, who managed the logistics of the move, ensuring that no small detail was overlooked. In an effort to offset the very significant costs associated with the relocation, the FDI created the Sponsor-a-Window Programme, whereby participants could adopt one of the 54 windows that offer a 560-degree view from the Geneva office. Thanks to the generosity of numerous donors, FDI has raised a total of 250,000 euros to date (more details coming soon).

As with many businesses and activities around the world, the FDI has been struggling to weather the economic storm. We face particular challenges—as a non-governmental, charitable organisation—to maintain existing channels and develop new avenues of revenue at a time when budget cuts and belt-tightening are standard practice. Nevertheless, we are well poised to move into 2010 under the financial discipline of our new Finance and Operations Director, Mr. Jérôme Fatkouer. Finances are at the heart of every FDI project and Jérôme brings a strategic approach that translates to clear management accountability of FDI finances together with greater outcomes’ evaluation of what we achieved for what we spent. This position is vital to our future and it gives me much pleasure to welcome Jérôme to the team.

I am also pleased to announce that Mr. Bio Khaw has joined our permanent staff as Senior Accountant. And beginning January 2010, Dr. S.J. Shantinath will join us as Head of Public Health. Of course, while welcoming additions to staff, goodbyes must sometimes also be said: Ms. Heather Sheppard and Ms. Berit Pedersen, both of whom were part of the FDI family for more than six years, have decided to leave us to pursue new and exciting opportunities elsewhere. We wish them well in their endeavours.

Members’ corner: The spirit of volunteerism

Dr Peter Swiss, Chairman of the Working Group on Ethics & Dental Legislation, and volunteer support staff to the Dental Practice Committee, will retire from his FDI activities next year after more than 40 years of service to the FDI.

Dr Swiss has been affiliated with the FDI since his student days, when in 1966, he was Treasurer of the International Association of Dental Students (IADS), an organisation strongly supported by the FDI. A year later Dr Gerald Leatherman, then FDI Executive Director, appointed Dr Swiss as the first FDI Student Liaison Officer. One of Dr Swiss’s responsibilities in this role was to attend IADS annual congresses on behalf of the FDI and to chair its General Assembly. Dr Swiss’s interest in international organised dentistry developed as a result of this role and was further strengthened when he was appointed a member of the British Dental Association Organising Committee for the 1974 FDI Annual World Dental Congress (AWDC) in London.

Following the AWDC in 1974, Dr Swiss was invited by Dr Leatherman to assist with the organisation of future FDI congresses. He also continued his commitment with the FDI as a speaker at several FDI congresses and as a member of the Commission on Dental Education & Practice (1985) and the UK delegation, becoming National Secretary in 1994. His particular interest in international dental ethics developed in the 1980s, following his appointment as Dental Secretary of the Medical Defence Union in 1982. Dr Swiss became a member of the FDI Ethics Committee, and in 2000, was elected Chairman. In 1998 he chaired the 5th International Congress on Dental Law & Ethics and in 2007 he coordinated the production of the FDI Dental Ethics Manual.

In 1999 the FDI became urgently in need of an Editor of FDI World and turned to Dr Swiss, who agreed to take on the role for two years. Later, in 2006, when the FDI was seeking a part-time Dental Practice Committee Coordinator, once again it turned to Dr Swiss for his assistance. He agreed to take on that role and turned to Dr Swiss for his assistance. He agreed to take on that role.

In contemplating his involvement with the FDI, Dr Swiss said he has seen the FDI develop and improve. “Until about 20 years ago, the focus of the FDI was largely on the interests of the developed countries and its congresses were attended predominately by participants from these member associations,” said Dr Swiss. “More recently, however, the FDI has expanded its work to cover a much wider area of the world and now has some of its major influence in the developing countries”. Over the years, Dr Swiss has attended 27 FDI congresses, beginning with the Brazil congress. He feels the time has now come for him to stand back and watch others to continue the great work of the FDI.

Save the date: 2010 Annual World Dental Congress

The FDI Annual World Dental Congress provides a unique gathering place for dentists to explore the profession’s latest technological, political and social developments through a World Dental Exhibition, FDI General Assembly and business meetings, the Scientific Programme (including limited attendance courses), and locally-inspired social events.

FDI World Dental Federation and the Brazilian Dental Association (ABD) have collaborated closely with local organisations and representatives to bring you a world-class event next year, More information about the Salvador congress is available on the FDI website.

About the publisher

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FDI Communications Manager

Aimée DuBrûle

The FDI Annual World Dental Congress will be held from 2-5 September in Salvador da Bahia, Brazil.

FDI World Dental Federation and the Local Organising Committee of the 2010 FDI Annual World Dental Congress (AWDC) are busy preparing for next year’s event, which will be held in Salvador da Bahia, Brazil, from 2 – 5 September.

Located on the northeast coast of Brazil, Salvador is the country’s third-largest city, boasting 54 km of beaches, a blend of American, African and European cultures, and an historical centre designated an official UNESCO World Heritage Site in 1985. As the country’s first capital (from 1549 to 1765), Salvador has a long and rich history, evident in the distinctive architecture, cuisine and culture that continue to define the city, drawing visitors from around the world and making Salvador one of Brazil’s top tourist destinations.

The FDI Annual World Dental Congress provides a unique gathering place for dentists to explore the profession’s latest technological, political and social developments through a World Dental Exhibition, FDI General Assembly and business meetings, the Scientific Programme (including limited attendance courses), and locally-inspired social events.

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FDI Communications Manager

Aimée DuBrûle
Minimally invasive cosmetic dentistry: A concept and treatment protocol for general practice

Dr Sushil Koirala  Nepal

Increased media coverage and the availability of free web-based information have lead to heightened public awareness and thus to a dramatic increase in patients' aesthetic expectations, desires and demands. Today, a glowing, healthy and vibrant smile is no longer the exclusive domain of the rich and famous and most general practitioners are forced to incorporate various aesthetic treatment modalities in their daily practice to meet this growing demand.

The treatment modalities of any health-care service are aimed at the establishment of health and the conservation of the human body with its natural function and aesthetics. The concept of minimally invasive (MI) treatment was initially introduced in the medical field and was adapted in dentistry in the early 1970s with the application of diamine silver fluoride. This was followed by the development of preventive resin restorations (PRR) in the 1980s and the atrophic restorative treatment (ART) approach and Carisil® in the 1990s. The major components of MI dentistry are the use of air abrasion, laser treatment or sono abrasion to gain cavity access and excavate infected carious tooth tissue through selective caries removal or laser treatment, cavity restoration by applying ART, PPR, or sandwich restoration, and the use of computer controlled local anesthesia delivery systems with emphasis on the repair of a failed restoration rather than its replacement. This, in turn, focuses MI dentistry on the caries-related topics and has not been comprehensively adopted in other fields of dentistry. Dr Miles Markley, one of the great leaders of preventive dentistry, advocated that the loss of even a part of a human tooth should be considered a serious injury and that dentistry's goal should be to preserve healthy and natural tooth structure. His words are much more relevant in today's cosmetic dental practice, in which the demand for cosmetic procedures is rapidly increasing. With the treatment approach trend towards the more invasive protocols, millions of health teeth are aggressively prepared each year in the name of smile makeovers and mutant orthodontics, neglecting the long-term health, function and aesthetics of the oral tissues.

The need for a new concept

Contemporary aesthetic dentistry demands well-considered concepts and TPs that provide a simple, comprehensive, patient-friendly and MI approach with an emphasis on psychology, health, function and aesthetics (Fig. 1). The need for a holistic concept and basic treatment guidelines was expressed by concerned practitioners, aesthetic dentistry associations and academies around the world for the following basic reasons:

• Owing to an increased aesthetic demand, aesthetic dentistry is becoming an integral part of general dentistry. The aesthetic outcome of any dental treatment plays a vital role in the patient's treatment satisfaction criteria.

In this article, I introduce a concept and TP for minimally invasive cosmetic dentistry (MICD), in order to address these facts properly and integrate the evidence-based MI philosophy and its application into aesthetic dentistry.

Defining MICD

As the perception of aesthetics and beauty is extremely subjective and largely influenced by personal beliefs, trends, fashion, and input from the media, a universally applicable definition is not available. Hence, smile aesthetics is a multifactorial issue that needs to be adequately addressed during aesthetic treatment. MICD deals both with subjective and objective issues. Therefore, in this article I define MICD as "a holistic approach that explores the smile defects and aesthetic desires of a patient at an early stage and treats them using the least intervention options in consideration of the psychology, health, function and aesthetics of the patient."  

The core MICD principles are:

1. Application of the sooner-the-better approach and exploration of the patient's smile defects and aesthetic desires at an early stage in order to minimise invasive treatments in the future;

2. Smile design in consideration of the psychology, health, function and aesthetics (Smile Design Wheel®) of the patient;

3. Adoption of the do-no-harm strategy in the selection of treatment procedures and the maximum possible preservation of healthy oral tissues;

4. Selection of dental materials and equipment that support MI treatment options in an evidence-based approach;

5. Encouragement of the keep-in-touch relationship with the patient to facilitate regular maintenance, timely repair and strict evaluation of the aesthetic work performed.

The main MICD benefits include:

1. Promotion of health, function and aesthetics of the oral tissues and positive impact on the quality of life of the patient;

2. Preservation of sound tooth structures (banking the tooth structure), while achieving the desired aesthetic result;

3. Reduction of treatment fear and increased patient confidence;

4. Promotion of trust and enhancement of professional image.

The MICD treatment protocol

In my experience, the TPs that are currently in use in aesthetic dentistry are mostly based on more invasive techniques and procedures. With the use of such protocols, cosmetic dentists are knowingly, or unknowingly, heading towards the over-utilisation of invasive procedures and the risk of irreversible damage to the hard and soft tissues. The need for a holistic approach in cosmetic dentistry that integrates professional image, patient's perception and quality of life is obvious. The core MICD principles serve as a guideline for the selection of treatment procedures, which allow the dental professional to prevent future dental issues and achieve the aesthetic and functional outcomes the patient desires.

The MICD treatment protocol aims to prevent future dental issues and achieve the aesthetic and functional outcomes the patient desires. It is crucial for the dental professional to consider these principles when selecting treatment options and procedures. The protocol integrates professional image, patient’s perception, and quality of life, resulting in a holistic approach to cosmetic dentistry. By applying this protocol, dental professionals can provide treatments that are not only aesthetically pleasing but also maintain oral health and function.
The intervention level of the treatment should always be as little as possible.

technologies in their practices, which is becoming a professional and ethical concern. The basic aim of the MICD TP is to guide practitioners in achieving optimum results with as little intervention as possible. The intervention level of the treatment in MICD depends on the type of smile defects and the aesthetic needs (objective measurement and subjective perception) of the patient.

The basic framework and pathway of the MICD TP are illustrated in Figures 2 and 3. It is the practitioner’s duty to incorporate all the necessary guidelines, protocols and regulations of the authorities concerned (state or affiliated professional organisations) into the MICD TP.

Phase I: Understand

In the first step of Phase I, the perception, lifestyle, personality, and desires of the patient are described. The primary goal of this first step is a better patient–dentist understanding. As the aesthetic perceptions of the dentist and the patient may differ, it is imperative to understand the subjective aesthetic perception of the patient. Various types of questions, personal interviews and visual aids can be used as supporting tools. In this step, the practitioner should ask the patient to complete the MICD self smile evaluation form. The information obtained will help estimate the perceived smile aesthetic score (a-score) and will be used as the base-line data in the evaluation step.

Next, diseases, force elements and aesthetic defects of smile are explored. Information on the medical and dental history, general health and specific health (oral-facial) of the patient is collected and complete dental and periodontal charting is performed. In order to understand the force elements, the existing occlusion, comfort, muscular activity, speech and phonetics are thoroughly examined with the evaluation of para-functional and other oral habits, comfort during mastication and deglutination, and temporo-mandibular joints (TMJ) movements. The necessary diagnostic tests, photographic documentation and the diagnostic study models are prepared during this step for the further exploration of existing diseases, force elements and aesthetic defects.

In the following step, the data collected is gathered to determine to the accepted normal values of a patient’s sex, race and age (SRA) factors. The aesthetic components of the smile are analysed in detail grouped into macro- (facial and dental midline relation, facial profile, symmetry of the facial thirds and hemi-faces), mini- (vitality of upper anterior teeth, smile arc, smile symmetry, buccal corridor, display zone, smile index and lip line) and micro-aesthetics (dental central dominance, teeth proportion, axial inclination, incisal embrasure, contact point, gingival shape, contour, embrasure and zenith height). The practitioner can now grade the smile in terms of the patient’s health, function and aesthetics as follows:

- **Grade A**: The established parameters of oral health, function and aesthetics are within normal limits and aesthetic enhancement is required only to fulfill the patient’s cosmetic desires.
- **Grade B**: The established parameters of oral health and function are within normal limits; however, the aesthetic parameters are below the accepted level. Aesthetic enhancement is necessary to improve the aesthetic parameters.
- **Grade C**: The established parameters of oral health and function are below the normal limits; however, the aesthetic parameters are above the normal limits. An aesthetic enhancement is necessary prior to aesthetic enhancement.

From the above, the practitioner will obtain a smile aesthetic grading in terms of the patient’s health, function, and aesthetics, as well as a complete overview over the smile aesthetic problems and solutions to macro-, mini- and micro-smile defects.

The patient’s PHA factors are the four fundamental components of aesthetic dentistry and must be respected to achieve healthy, harmonious and beautiful smiles. The design step depends on the information obtained from exploration and analysis. The information on psychology is subjective in nature; however, health, function and aesthetic analysis provides the objective information that will guide the design with the various established and basic principles of smile aesthetics and also the feasible and practical extent of the aesthetic desires of the patient. The aesthetic mock-up, manual tracing, digital makeover and smile catalogues are some of the popular tools used in this step. A new smile, alternative designs, types of treatments involved, complexity, possible risk factors and complications, treatment limitation, and tentative costs should be established during this step.

For easy application, the aesthetic treatments in MICD are categorised as follows:

- Type I: Micro-aesthetic components;
- Type II: Mini-aesthetic components;
- Type III: Macro-aesthetic components; and
- Type IV: Aesthetic components of facial and dental midline relation, facial profile, symmetry of facial thirds and hemi-faces.

As the treatment modality depends on the professional capability and experience of the practitioner, simple and practical methods are used to categorise the MICD treatment complexity:

- **Grade I**: Treatment that may require consultation with a specialist (preventive, simple oral surgery/endo/periodontics/implants, short orthodontics);
- **Grade II**: Treatment that requires the procedural involvement of other dental specialists (complex endodontics/periodontics/orthodontics) but not oral and maxillofacial surgery or plastic surgery;
- **Grade III**: Treatment that requires the procedural involvement of oral and maxillofacial surgery or plastic surgery.

With the aid of this simple grading system, any practitioner can determine the complexity of the treatment involved for the accomplishment of a new smile design for an individual patient and can plan for the necessary multidisciplinary support.

The last step of this phase is the most important in MICD TP because in this step the patient is presented with an image of his or her future smile. Visual aids, such as a smile catalogue, aesthetic mock-ups, manual sketches, digital pictures, computer-designed artwork or animations can be used as presentation tools. The results of the design step are systematically presented to the patient with professional honesty and ethics. All pertinent queries of the patient related to the proposed smile need to be addressed during presentation. The treatment complexity, its limitations, the risks involved, possible complications, treatment cost estimation and maintenance responsibility must properly be explained to the patient. The patient is thus involved in finalising the treatment plan and is expected to sign a written informed consent form before proceeding to Phase II.

Phase II: Achieve

As per the TP, which is finalised during the presentation step, all necessary preventive and interceptive (curative) treatments are conducted in order to establish the proper health and aesthetic conditions of the patient. The patient is thus involved and can determine the complexity of the treatment involved for the accomplishment of a new smile design for an individual patient and can plan for the necessary multidisciplinary support.

The enhancement step of MICD is focused on the fulfilment of the patient’s aesthetic desires, which can be grouped into two categories based on the patient’s needs and wants. Even though it is sometimes difficult to draw a clear line between the two and their related treatment, in MICD they are categorised as follows:

- **Needs objective restorative needs of the patient in harmony with the treatment plan**
- **Wants aesthetic enhancement**

For easy application, the aesthetic treatments in MICD are categorised as follows: Type I: Micro-aesthetic components; Type II: Mini-aesthetic components; Type III: Macro-aesthetic components; and Type IV: Aesthetic components of facial and dental midline relation, facial profile, symmetry of facial thirds and hemi-faces.

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- **Grade III**: Treatment that requires the procedural involvement of oral and maxillofacial surgery or plastic surgery.
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the SRA factors and the emphasis on tissue treatment (nature-mimetic smile enhancement) wants subjective desires of the patient, which may not be in harmony with the SRA factors (cosmetic smile enhancement).

During any want-based aesthetic treatment, where healthy oral tissue is treated with no direct benefit to health or function, the treatment modalities should be within the scope of non-invasive (NI) or MI procedures. The patient’s cosmetic desires alone should not be the rationale for the treatment. Do no harm! should always be the credo pertinent to all dental treatment procedures.

Evaluation is the final step of MI CP, any ‘completed’ treatment without a proper evaluation is considered incomplete in MCD protocol. The following components need to be evaluated:

- Global patient satisfaction: After receiving aesthetic dental treatment, the patient is requested to complete the MCD exit form, in which the patient evaluates his or her new smile, gives a second perceived smile aesthetic score (b-score), and indicates his or her overall satisfaction score. The b-score is compared with the previous a-score. This process helps determine the patient’s actual satisfaction status. In MCD, this is the main parameter for evaluating a patient’s aesthetic satisfaction.

Clinical success: Clinical success is a multifactorial issue: Selection of proper cases (the patient), restorative materials, TP and their correct and skilful application are the key factors for clinical success. Therefore, MI CP suggests self-evaluation of the following four factors (4Ps) using the MCD clinical evaluation form:

- Patient factors: regular maintenance status, compliance issues and attitude of the patient towards aesthetic treatment;
- Product factors: biocompatibility, mechanical and aesthetic quality of the products used for the treatment;
- Protocol factors: TP aimed in terms of its simplicity, predictability and its evidence-based nature;
- Professional factors: existing knowledge and skills, and attitude towards developing these.

Detailed clinical documentation of the case during maintenance and evaluation can provide various cues to the practitioner in the evaluation of his or her clinical success in terms of case planning, material and protocol selection, as well as his or her existing restorative skills. I believe that a thorough evaluation can support any practitioner in imitating practice-based research and keeping up-to-date with the recent trend of evidence-based dentistry (Figs. 4a–5b).

MCD treatment modalities

Various types of treatment modalities are available in MCD. Their effective use depends on the level of smile defects, type of smile design, proposed treatment type and the treatment complexity grade. There is only one principle in selecting treatment modalities in MCD: always select the least invasive procedure as the choice of the treatment.

The two categories of MCD treatment are NI and MI treatment (Table 1). However, conventional invasive treatment modalities may also be required, depending on the complexity of the case.
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Complete maxillary implant prosthetic rehabilitation utilising a CAD/CAM fixed prosthesis

Dr Neo Tee-Khin, Dr Ansgar C. Cheng, Dr Helena Lee & Rev. Loo
Specialty Dental Group
Singapore

Endosseous implant treatment has been widely reported as a highly predictable treatment modality with a low percentage of clinical complications. Pursuant clinical judgement and careful consideration of the risks and benefits of various treatment options are essential for the treatment planning and long-term success of prosthetic treatment.

Traditional implant prostheses are commonly fabricated using acrylic resin teeth supported by a metal framework. Significant space is designed at the tissue surface of the prosthesis to enhance oral hygiene maintenance. However, application of this prosthetic design in the maxillary arch is occasionally aesthetically inadequate and speech may be compromised.

Conventional porcelain-fused-to-metal restorations require the placement of labial restoration margins below the free gingival margin in order to mask the hue and value transition between the sub-gingival implant sub-structures and the supra-gingival crown restorations. From a periodontal point of view, sub-gingival placement of restoration margins is related to adverse periodontal tissue response. A result, restoration margins are best placed coronally from the free gingival margin.

Porcelain-fused-to-metal restorations are commonly used in the posterior teeth because of their well-documented long-term clinical track record. CAD/CAM ceramic-based materials are prescribed nowadays, owing to their demonstrated promising physical properties and clinical longevity.

This article describes the clinical application of high-strength zirconium oxide restorations in the prosthetic management of an edentulous maxilla with a failing implant prosthesis.

Clinical report
A 62-year-old female with an implant-supported maxillary prosthesis was evaluated at the Specialist Dental Group in Singapore. She presented clinically with a maxillary fixed complete denture supported by six endosseous implants (NobelReplace, Tapered Groovy, Nobel Biocare). The prosthesis had acrylic resin teeth supported by a gold alloy metal framework. The implant at the patient’s maxillary right canine area was exposed. No symptoms were reported by the patient (Fig. 1).

An occlusal examination revealed a stable maximal inter-cuspid position with insignificant centric relation to maximal intercuspation slide at the teeth level. A canine-guided occlusal scheme was noted. No para-functional habits were reported. Sub-optimal maxillary lip support was noted. A significant amount of dead space was identified between the intaglio surface of the prosthesis and the maxillary soft tissue.

Upon removal of the maxillary prosthesis, all the maxillary implants were found to be osseo-integrated. The patient desired to correct the failing implant, restore lip support, masticatory function and facial aesthetics.

The overall treatment plan included removal of the implant at the maxillary right canine area, replacement of a new implant at the maxillary right canine region and fabrication of a full-arch, zirconium oxide-based ceramic restoration in the maxilla.

Under local anaesthesia, the implant at the maxillary right canine area was removed surgically (Fig. 2) and a new 15 mm-long regular platform implant was placed (NobelReplace, Tapered Groovy). The new implant was submerged and primary wound closure achieved. Her existing prosthesis was re-inserted during the healing period to serve as a provisional prosthesis. Once osseointegration was achieved a few months later, the new implant was exposed and the maxilla was ready for prosthetic rehabilitation after a few weeks of soft-tissue healing.

Six implant-level impression copings (NobelReplace) were placed onto the maxillary implants. High-viscosity, vinyl polysiloxane material (Aquasil Ultra Heavy, DENTSPLY DeTrey) was carefully injected around all the impression copings. A stock tray loaded with putty material (Aquasil Putty, DENTSPLY DeTrey) was seated over the entire maxillary arch to make the definitive impression. A jaw relation record at the treatment vertical dimension was made with a vinyl polysiloxane material (Registil PR, DENTSPLY DeTrey). The maxillary and mandibular definitive casts were mounted arthrokinematically in the centre of a semi-adjustable articulator (Hanau Wide-vue, Tele-dyne Waterpik) using average settings. The custom zirconium oxide abutments with gold-alloy fitting surface (Poeera, Nobel BioCare) were CAD/CAM fabricated according to the prosthesis design.

The development of the planned definitive maxillary restoration was carried out using a CAD/CAM process. The maxillary...
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Fig. 3: Completed maxillary implant-supported prosthesis; note the placement of the supra-gingival margins.

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definitive cast with the custom full-ceramic abutments were scanned (Zeno Scan, WIELAND Dental+Technik), and the prosthesis framework was designed using a software program (D700, 3Shape). The framework was milled in zirconium-base material (Zeno Zr Bridge, WIELAND Dental+Technik) with a milling machine (Zeno 4030 M1, WIELAND Dental+Technik). The prosthesis framework was sintered according to the manufacturer’s recommendations. Subsequently, over-laying low-fusing, tooth-coloured porcelain material (IPS e.max, Ivoclar Vivadent) was manually applied onto the exterior to create proper anatomic form (Fig. 3). Low-fusing, gingival-coloured porcelain material (IPS e.max) was applied to create proper lip support (Fig. 4).

During the delivery clinical session, the old prosthesis was removed and the new custom abutments were torqued to 32 Ncm (Fig. 5). The new prosthesis was tried-in to verify colour, occlusion, lip support, teeth form, and comfort. Upon confirmation of the patient’s acceptance, the implant abutments were sealed in gutta-percha (Fig. 6) and the prosthesis was cemented in resin-modified glass-ionomer luting agent (RelyX Unicem, 3M ESPE).

The patient was evaluated two weeks post-operatively. Anterior guided occlusal schemes were verified intra-orally before and after prosthesis cementation (Fig. 7). The patient reported no discomfort and she had been functioning well with the new restorations. No abnormal clinical signs were noted.

Discussion
Osseo-integration is a well-documented and predictable clinical treatment option. On the other hand, management of implant failure is also a clinical reality. In this clinical report, the failure of one implant at a crucial location indicated the need for re-fabrication of the whole implant prosthesis. As the patient desired a high level of aesthetics, full-ceramic restorations were selected. By prescribing tooth-coloured ceramic abutments and full-ceramic restorations, prosthesis margins were made at the gingival level and gingival retraction procedures were eliminated during impression and prosthesis insertion.

Full-arch prosthodontic rehabilitation using fixed prostheses usually requires longer-term provisional restoration in order to facilitate a predictable treatment outcome. In this patient, the existing maxillary prosthesis served as a long-term provisional restoration for verifying her adaptability and multiple professional clinical adjustments of provisional restorations were not required. This treatment sequence increased the margin of safety in the execution of the definitive full-ceramic restoration. Intra-oral verification of the new treatment occlusal scheme and detailed in situ clinical adjustment of the restorations on the day of prostheses insertion still formed the essential foundation for proper treatment execution. In any major prosthodontic treatment, the patient should be informed of the potential financial and time implications should the need for re-fabrication of the restorations arise.

Conclusion
The functional management of an edentulous maxilla using a full-ceramic implant-supported maxillary prosthesis has been reported. New CAD/CAM-based restorative materials were used in treating this case. The use of high-strength full-ceramic restorations enhances overall aesthetic predictability and long-term functional outcome.

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

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“HIV tests should be offered in every dental practice”

An interview with Dr Catrise Austin, VIP Smiles, New York

According to the latest figures from the United Nations Organisation UNAIDS, more than 34 million people worldwide are infected with the HIV virus. Since it can take up to ten years before progressing to AIDS, early testing can be a life-saving factor. New tests for HIV checks in dental practices have recently been developed. Dental Tribune Asia Pacific spoke to Dr Catrise Austin, who maintains a dental practice on 57th Street in New York City, to speak about HIV testing in her practice and how such testing could help to create a heightened awareness of the disease amongst patients.

Dental Tribune Asia Pacific: Dr Austin, could you tell our readers the reason you decided to offer free HIV tests to your patients?

Dr Catrise Austin: The idea for offering free HIV tests to my patients arose earlier this year once I had learnt that I am currently not aware of other tests that may diagnose diseases other than HIV/AIDS; it would be fantastic if we were able to diagnose everything through the mouth.

How does the test work?

The test is called OraSure Quick and it uses antibodies in the blood stream. It uses an oral swab, which we take under the upper and lower lips and place in a developing solution directly at the beginning of our dental appointments. The results are available within 20 minutes and we can start with normal treatment immediately after we have done the test.

Unfortunately, I often encounter scepticism from some of my colleagues about the comfort level and the way to introduce the test to a patient in a dental setting. I tell them every time that the test is very easy to apply without making the patient feel uncomfortable. I guess that like most new ideas it takes some getting used to, but it will be successful because we are helping to save people’s lives. So, we hope to get more dentists all over doctors other than medical doctors can offer HIV testing in their practices. I said to myself why not add another service to our existing checklist of lesions or cavities and give patients the opportunity to know their status in a different setting. I saw this as a unique opportunity for me as a dentist to diagnose HIV in its early stages.

Unfortunately, the virus is still highly prevalent. In New York City alone, there are 94,000 confirmed cases and it seems that the number of infections is not improving in 2009/2010.

Why should dental offices test for infectious diseases like HIV/AIDS or Tuberculosis in the first place?

My opinion is that HIV tests should be offered in every dental practice because the oral cavity is one of the first places that shows signs of HIV infection. You can detect signs of herpes and other sexually transmitted diseases in the mouth as well, and so we look for lesions and other signs or symptoms of the disease.

We are fully trained and prepared in case a test is positive. If a patient tests positive, we counsel him or her immediately and help him or her call their primary health physician to schedule a confirmatory test. It is important to us that the test that we offer is a screening test only and not a confirmed test. If a patient does not have a physician, we usually refer him or her to one of the clinics in the New York City area with which we have a partnership.

There are thousands of people in the US and more around the world who are unaware that they are HIV/AIDS infected. Do you think that regular checks in dental practices could help to create more awareness of the disease?

That is something I would like to see happening as more dentists begin administering the test. It is time to recognise that we should be concerned with the patient’s holistic health not only his or her oral health.

I am the first dentist in New York to offer the test and I would love to be the trail-blazer and help to make the test the standard of care in dental practices around the world. The greatest joy for me is when a patient says that he or she would have never undergone this test if it were not for me.

Thank you very much for the interview.

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