States agree on global mercury ban but leave dental amalgam out

Daniel Zimmermann
DTI

GENEVA, Switzerland: Following four years of negotiations, representatives of more than 140 governments recently paved the way for a worldwide ban of mercury-containing products. They also agreed to a number of measures for reducing pollution caused by industrial use of the metal, such as in dental fillings.

The treaty, named the Minamata Convention after a Japanese town seriously affected by a mercury disaster in the 1950s, is expected to come into full effect by 2020. It will be signed in October at a special meeting in Japan, according to representatives of the United Nations Environmental Programme, which hosted the meeting of the International Negotiating Committee on Mercury last month in Geneva.

Delegates of over 140 countries discussed the global mercury ban. (DTI/Photo courtesy of UNEP, Switzerland)

Measures will include the support of developing nations to develop alternatives to processes that utilise mercury and to reduce emissions through new technologies.

Super-gel fights superbugs

A new effective tool that could help to fight multidrug-resistant bacteria has recently been unveiled by researchers from Singapore. Developed in partnership with IBM Research, the yet-unnamed hydrogel was found to destroy various types of fungi and bacteria upon contact in lab tests, including methicillin-resistant Staphylococcus aureus (MRSA), the main cause of most hospital-acquired infections worldwide.

According to the researchers, the material made of a newly developed polymer is biodegradable and therefore is eliminated naturally after use. If approved, it will be used for a new range of medical and consumer products, which could include anti-bacterial coatings for medical devices and dental fillings. Hospital-acquired infections through MRSA, for example, are among the leading causes of death worldwide. In Singapore alone, patients with microbial infections are ten times more likely to die if hospitalised, according to national statistics.

Endo specialists to meet in Korea

The Asian Pacific Endodontic Confederation will hold its 17th Scientific Conference in Seoul, South Korea, in March this year. The meeting, which is expected to attract up to 1,000 endodontic specialists from the APAC region, will also feature a number of internationally renowned speakers.

Asthma affects dental development

New evidence from India suggests that a compromised airway has an effect on dentoalveolar morphology in humans. Among other things, the researchers found that the inter-arch and the inter-incisal widths were smaller in both arches in asthmatic children.

Colleges raided for bribery

A number of dental colleges in India have recently been investigated by the Central Bureau of Investigation in New Delhi for having paid money to members of the Dental Council of India in an effort to obtain permission for their postgraduate courses. According to newspaper reports, at least ten facilities run by four institutions in the southern province of Tamil Nadu were raided and two dentists arrested on bribery charges by the anticorruption agency in January.

India has almost 500 colleges, producing 50,000 new dentists every year, of which 90 per cent are private. Permission to operate is granted by the council, which many have accused in the recent past of being corrupt and having granted permission for colleges that did not fulfil the required standards for educators and teaching equipment.

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Taiwan dentists more compliant with infection-control requirements

TAIPEI, Taiwan: Figures from two surveys conducted over a decade among general practitioners in Taiwan indicate that infection-control measures in dental practices have significantly improved. Of those surveyed in 2010, the majority of dentists reported wearing and regularly changing gloves when treating patients. Moreover, the survey found that all the respondents wore surgical masks.

Head caps or protective eye-wear, however, was only worn by one in four dentists.

Compliance with wearing protective gear was the highest among young female practitioners who treated more than 20 patients per day, according to the study. It also revealed that dentists were kept more up to date with developments in infection control in 2010 by using the Internet and through continuing education seminars than they were ten years ago.

According to the researchers from the Taipei Medical University and the National Taiwan University, the recent numbers are a significant improvement on the first survey conducted by the same team in 1999. Back then, 500 questionnaires were randomly sent to dentists who at this time were members of the Taiwan Dental Association.

While only 52 per cent completed the questionnaire that year, more than 71 per cent (or 285 respondents) did so in the follow-up survey ten years later. To date, the island state has more than 11,000 registered dentists.

The researchers suggested that the improvement could possibly be traced back to the SARS epidemic in Asia in 2005, which saw Taiwan highly affected with a final death toll of 84 and concern raised by patients and the public nationwide about the risk of disease transmission in health care settings, Public funding and requiring dentists to attend continuing education courses on infection control have also contributed to the improvement in recent years, they said. They recommended conducting further studies and increasing continuing education opportunities in the subject nationwide.

“Although infection-control practices have improved over time in this Asian country, there is still much room for increasing compliance rates regarding wearing a head cap, protective eyewear and a face mask, and disinfecting impression equipment,” the researchers state in the report.

Since 2005, practitioners in Taiwan have been entitled to SS1 for infection-control measures from National Health Insurance for every patient they treat.

Compliance with wearing protective gear was the highest among young female practitioners (DTI/Photo Pendalist)
Australia steps ahead in virtual learning

CRAWLEY, Australia: Virtual methods of education are increasingly finding their way into dental schools worldwide. Students at the University of Western Australia’s School of Dentistry have been the latest to get hands-on with the Moog Simodont Dental Trainer, a sophisticated dental-procedure simulator developed in the Netherlands and the US.

The system, recently launched for the new Doctor of Dental Medicine degree programme, allows students to perform basic tasks like drilling and caries removal realistically in a virtual environment. A high-fidelity feedback technology used in the training of pilots—and in other fields called haptic—provides a realistic sense of touch similar to treating real patients. The investment, worth almost US$1 million, has received funding by Health Workforce Australia, an Adelaide-based government agency set up in 2008 to help the country to develop a sustainable medical and dental workforce.

According to Prof. Andrew Smith, head of the dental school, by replicating preclinical situations in a virtual setting almost no tissue or material is consumed. More importantly, the system allows students to practise drilling on human teeth that have unique morphologies, a process not yet possible to replicate using plastic teeth or teeth derived from animals.

“It is essential that a student be able to practise the tasks using those unique formations,” he told Dental Tribune Asia Pacific. “The computerised dental trainers are able to meet these demands.”

UWA is not the first university in Australia to have employed the unique technology. Among others, trials have been conducted by the Griffith University’s School of Dentistry and Oral Health in Southport in 2011. According to Moog, there are now over a dozen universities worldwide, including the University of Michigan dental school in the US, that are training students in this way. A study conducted there in 2012 found that virtual teeth replicated by the Simodont simulator are more realistic than the plastic models traditionally used.

Smith said that 14 units had recently been purchased and installed at UWA to help train 1,150 students at the school over the next ten years. So far, the units have been used in interprofessional training programmes with dental nurses, for remedial training and for testing candidates for the dentistry programme, he said.

“An important aspect, however, is the ability to teach the students how to use a mirrored image to allow completion of drilling tasks when these cannot be viewed directly. Other tasks available allow the diseased portion of the tooth to be cut away on both primary and permanent teeth,” Smith explained.

“Very soon we will have the exercises for training students to cut preparations on teeth for crowns and in the future bridges will be also taught.”

Lab with Simodont dental trainers. (DTI/Photo courtesy of UWA, Australia)
Dear reader,

Unlike other professions, the closure of a newspaper or magazine, even a competing one, always triggers conflicting emotions for journalists. While we may seem to contend fiercely for the next exclusive story or the most creative headline, there is an unspoken solidarity among all members of the journalistic community. In this respect, the end of Asia’s oldest regional dental newspaper APDN and its Latin American sister publication is a catastrophe, as fewer publications mean not only more writers and editors without a job but also less diversity, something that has plagued our colleagues in daily newrooms around the world.

As one of the two remaining dental titles for the Asia Pacific region, we are determined to fill this gap. This commitment, however, is going to make our work a lot more difficult, despite the reduced competition. Therefore, our goal is to keep our standards high and our minds open to all aspects and to the many voices of the dental profession.

We intend to do so with this edition with an interesting and revealing article from Nova Southeastern University by Prof. Steven N. Abel on HIV testing in dental practices, a trend that has recently gained momentum in the US, where more people tend to visit their dentist rather than their doctor.

The recent threat of an Ebola virus epidemic in Africa is an example. Last August, the deadly outbreak of this virus claimed 16 lives and led to the Ugandan president’s call for citizens to limit physical contact with each other.

Dental health-care workers everywhere need to be ever vigilant and maintain meticulous infection control. The data emerging from at least one Asian city is, therefore, comforting. Researchers at the Taipei Medical University in Taiwan found that current dentists are better educated about and practise better infection control than a decade ago, a significant improvement on the first survey conducted by the same research team in 1999.

It is heartening to note the general improvement in infection control in this community, but I suspect that Taiwan may be an exception rather than the rule.

A few months ago, a dental assistant in Tennessee in the US complained of the dentist not wearing a mask, not washing his hands, not replacing gloves, and not sterilising the handpiece. I do not know the outcome of this case, but the Yahoo response asked her to report the situation to the health and safety office in the area.

How such a situation could arise in a so-called developed country is unfathomable. Other similar incidents are reported in the mass media sporadically.

The bottom line is that appropriate infection control is a reality that we have to face head on...”

“The bottom line is that appropriate infection control is a reality that we have to face head on...”

Dental amalgam is due to the toxic effects. Since it is an element, it will never break down into less harmful elements. On the contrary, part of the elemental mercury released is transformed into methyl mercury, which is bioaccumulated in living organisms, often reaching hazardous levels in popular food sources such as tuna, cat-fish and perch. This is a serious problem.

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Microbes are all around us. They are one step ahead as new infections emerge and old infections re-emerge periodically in different parts of the world.

“The bottom line is that appropriate infection control is a reality that we have to face head on...”

Infection control measures in dentistry: A big-ticket item

Over 750 participants from around the world recently agreed on reducing the use of dental amalgam at a meeting on the UNEP Minamata Convention held in Geneva, Switzerland, in mid-January to prepare a global legally binding instrument on mercury. The decision to phase down the use of dental amalgam is due to the toxicity and hazardous effects of mercury released from these fillings. Mercury is released to air and water not only through insertion and removal of amalgam fillings, but also through every wear by chewing and hot beverages ingested by persons with these mercury-containing dental fillings.

Dental amalgam is no longer used in Japan and is banned in Norway, Sweden, and Denmark, where tooth-coloured and environmentally friendly alternatives are the predominant filling material. Although the hazards of mercury have been well known ever since, the practice of restoring teeth decayed by caries with amalgam has survived, despite the effective and affordable mercury-free alternatives that are available today.

Atraumatic Restorative Treatment using handtools and high-viscosity glass ionomer cements as filling material, for example, has turned out to be a viable means of providing dental care in areas where the only dental treatment available is the extraction of teeth. It is also the first choice for primary teeth in Sweden, owing to its patient-friendly properties and handling and short training period.

Both composites and glass ionomer cements bear their full environmental costs, while dental amalgam would be a restorative material of choice were it to carry its environmental costs.

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Contact Info

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UK’s first private dental school to open in Leicester

LEICESTER, UK: The United Kingdom’s first independent dental school—aimed mainly at international students—is soon to open in Leicester. From September 2013, the school will enrol 100 students annually for a five-year degree course.

The new venture is a partnership between the Leicester Dental Teaching Academy and the University of Buckingham. The Bachelor’s degree in Dental Surgery to be offered will be conferred by the University of Buckingham. The course is designed to meet General Dental Council outcome measures and European standards, as well as the requirements of the Quality Assurance Agency for Higher Education.

The degree course is specially designed to appeal to an international market. Students will be introduced to patient care early on in their training and will be given a thorough grounding in business development, management and enterprise. They will gain an appreciation of the international business environment and cultures in other parts of the world, such as India, Nigeria and China, as well as the impact of oral disease on societies around the world.

Once the school is up and running, it’s planned to establish a charitable trust and to engage in research, as well as to award bursaries to promising students with limited means of support.

(Edited by Daniel Zimmermann, DTI)
NEW YORK, USA: The Fluoride Action Network (FAN) has criticised the authors of an article recently published in the *Journal of the American Dental Association* (JADA) for urging dentists to promote fluoridation even though many of them are not well informed about the issue.

In their article, Drs Molly L.R. Melbye, a senior research fellow at the Department of Oral Health Sciences, University of Washington, and Jason M. Armfield, senior research fellow at the Australian Research Centre for Population Oral Health, University of Adelaide, state that “Studies of dentists’ attitudes about water fluoridation suggest that a lack of knowledge and preparedness are barriers to discussing the topic.” In a survey, more than half of the respondents believed they needed more information and training on the issue, the authors wrote.

According to FAN, in the same article, the authors urge dentists to promote fluoridation, despite their lack of knowledge.

“It is reckless to urge dentists to tell the public that fluoridation is safe when they are not on top of the literature,” stated FAN director Dr Paul Connett. “Their qualifications pertain to teeth. They are not qualified to assess what damage ingesting fluoride may cause to the rest of the body.”

According to FAN, Armfield and Melbye encourage dentists to promote the safety of fluoridation based upon this misleading assurance: “There are no known harmful effects from ingestion of water that has had fluoride added to it at or about 0.7–1.2 mg/l. No systematic reviews of the literature have shown any negative health effects from ingestion of water fluoridated in or near this therapeutically safe range.”

Connett said that this assertion is dangerously misleading because it confuses concentration and dose. Harm has been found at doses that are commonly experienced in populations drinking artificially fluoridated water. Furthermore, it ignores that most basic health studies have not been conducted in countries that practice fluoridation. The absence of research is not the same as absence of harm, he stated.

According to Connett, the assertion also overlooks the serious findings reported by the US National Research Council in 2006 that subsets of the population—including bottle-fed infants—are exceeding the US Environmental Protection Agency’s safe reference dose (0.06 mg/kg of bodyweight per day) by drinking fluoridated water.

Fluoridation is still a subject of controversial public debate, as some believe it can only benefit oral health and some think it has a negative impact.

FAN is calling nations that still fluoridate their water to end the practice. According to the international organisation, “it is becoming increasingly clear that fluoridating water supplies is an outdated, unnecessary, and dangerous relic from a 1950s public health culture that viewed mass distribution of chemicals much differently than scientists do today.”

The article, titled “The Dentist’s Role in Promoting Community Water Fluoridation: A Call to Action for Dentists and Educators,” was published in the January issue of the *Journal of the American Dental Association* which is published in Chicago.
“IDS makes an important contribution to our overall business results”

An interview with Katharina C. Hamma, Chief Operating Officer of Koelnmesse

In less than two months, one of Germany’s leading trade show organisations will again be welcoming dental professionals from all over the globe to Cologne for the 51st International Dental Show. Dental Tribune International had the opportunity to speak with Koelnmesse CEO Katharina C. Hamma about the event and what can be expected from the world’s largest dental fair.

Dental Tribune International: Ms Hamma, you have been working as Chief Operating Officer of Koelnmesse since early last year. In your opinion, what makes the fairground in this city on the Rhine so special?

Katharina C. Hamma: One of the main advantages of Koelnmesse is its centralised location, with its host city Cologne literally in the centre of Europe. There are 155 million Europeans living within a radius of 500 kilometres from Cologne. This signifies a significantly large share of the European Union’s gross domestic product.

The location and the accessibility of the fairground itself are optimal, as it is only a stone’s throw from the city centre. All means of transportation can be reached within minutes. During the show, all important long-distance trains will stop at the main station in Cologne and at the Köln Messe/Deutz station. The Cologne/Bonn airport serves 108 countries in the European and international destinations and is a central hub for low-cost carriers.

The InterCity Express links Koelnmesse with four more international airports in Frankfurt/Main, Düsseldorf, Amsterdam in the Netherlands and Brussels in Belgium. All these factors make it quick and easy for exhibitors and visitors to reach Koelnmesse.

Despite the weak global economy, the German trade show sector is doing surprisingly well and we think the reasons for this are:

The German trade show sector is leading globally and fare-most fairs for several industries, such as the IDS, are held in the country. Owing to this, companies from all over the globe regularly attend German trade shows in order to access new markets, even in times of economic difficulty. Moreover, trade shows are a very effective marketing instrument.

Germany also boasts a very stable economy and demand for industry products.why trade shows in the country are of particular interest for companies wishing to expand their business in Germany.

With a revenue of €235 million, the last fiscal year has been one of the most successful in the history of Koelnmesse. How much did the IDS contribute to the results?

The International Dental Show is one of our most important events and there are only a few trade shows in Cologne that attract more exhibitors and visitors. Therefore, the trade fair makes an important contribution to our overall business results.

The number of registered exhibitors at IDS 2013 is already at the same level as the past show. What are your expectations for your first IDS?

With 17 joint participations again in March 2015, with booths representing Argentina, Brazil, Bulgaria, China, Great Britain, Israel, Italy, Japan, Pakistan, South Korea, Russia, Taiwan and the US.

What role do your foreign subsidiaries play in this development, and what image does the show have outside of Germany in general?

Koelnmesse has a global network of affiliates in more than 80 countries that lend significant support to the main team in Cologne in terms of attracting exhibitors and visitors. The main advantage is, of course, that the IDS is the leading international coming IDS. How have the existing measures been working out so far, and what will be done from your side to prevent the distribution of counterfeit goods?

We started an initiative called No Cop! Pro Original a couple of years ago that was intended to support exhibitors actively in their fight against counterfeits. There is a counter at the fairground, for example, that serves as a contact point for questions with regard to copyright violations. Experts are also on site to provide information and further help. If necessary, Koelnmesse employees can also provide and establish contacts with lawyers specialised in this particular area.

Ahead of the show, exhibitors should ensure that they really own the trademark rights for their respective products and brands. Documentation should be at hand in order to be able to act in case of a suspected copyright violation. Should an exhibitor find out that its trademark rights have been violated, it should immediately seek to obtain a declaration to cease and desist.

Should Koelnmesse be aware of a past or imminent violation by an exhibitor, it will point out the legal consequences of this to the exhibitor. If the company has been convicted of product piracy, Koelnmesse reserves the right to exclude the company from exhibiting at all future events of this kind. We are very active in supporting exhibitors in the fight against piracy.

One of your main goals as CEO is also to homogenise business structures. What impact is this going to have on the IDS?

I have been responsible for all business operations of Koelnmesse since early last year, which gave us the opportunity to utilise synergies better internally in our sales team and externally with our partners. All our events will benefit from this change, including the IDS.

For the IDS, you are working closely with the GFDI, a subsidiary of the German Dental Manufacturers’ Association. How has this collaboration been experienced?

The GFDI as the organiser and Koelnmesse as the staging company share a long and fruitful relationship. In particular, we are implementing all measures necessary for the successful realisation of the show, including the acquisition and support of exhibitors, running promotion and marketing campaigns in order to attract visitors, and the logistics and organisation during the five days of the event. All this takes place in close consultation with the GFDI.

You have no prior work experience in dentistry. Have you been surprised by what the field has to offer, and will you be visiting the show?

I have been welcomed warmly by the dental community and already learned a lot about the latest trends in dentistry. I am confident that there will be many innovations at the IDS that will make dental visits much more comfortable for patients. I am looking forward to seeing everything live at the IDS in March.

This year, the IDS will take place in five halls. Are there any changes in the overall concept, and if so when can we expect to see them implemented?

Both the GFDI and Koelnmesse consider the success of the IDS as confirmation of the show’s concept. Therefore, we will be sticking to the successful formula of the joint event in the near future, which entails focusing on business and product information presented at booths by exhibitors. Grouping halls according to dental specialties is currently not on our agenda. Whether changes will have to be implemented will be discussed with the GFDI after the next IDS.

Thank you very much for this interview.
DenTech Shangh hai to host dental CAD/CAM forum in 2013

DT Asia Pacific

SHANGHAI, China: The organiser of DenTech China has announced a forum solely dedicated to dental CAD/CAM to be held in an upcoming show in October this year. It will feature internationally renowned experts and cover several fields related to digital dentistry, including digital imaging, digital impression taking and image-guided implant surgery, representatives of Shanghai UBM ShowStar Exhibition said.

The forum will be held alongside the industry exhibition and other specialty forums on topics like implantology. In addition to leading providers of dental CAD/CAM, International Dental Products for China, a Chinese dental technology magazine published by German publisher Röser, is supporting the event.

While the penetration of dental CAD/CAM is still considered to be low in China, industry sources estimate that the market will grow by double digits in the next five years owing to a large influx of outsourced lab work from other countries and a higher demand for all-ceramic CAD/CAM-manufactured prosthetics in the rising Chinese middle class. According to the Canadian dental research provider data Research, this segment is currently the fastest growing in the country, with an annual growth rate of approximately 4.2 per cent per year.

Australia’s largest dentistry chain changes owner

DT Asia Pacific

GURGAON, India: After only 22 months, health care group Fortis is divesting its investment in the Australian dental office network Dental Corporation Holdings. The majority stake of 64 per cent, valued at an estimated AUS$270 million (US$284.6 million), has been offered to the Australian arm of the British United Provident Association (Bupa) in an effort to cut debt, the Indian company said in a statement last month.

Fortis Healthcare International, which runs dental service businesses in India and Hong Kong, among other APAC countries, acquired its first stake in Dental Corporation in February 2011. While the number of dental practices has grown by almost 40 per cent since then, according to the company, original plans to export the Dental Corporation model to other countries in the Fortis network have been largely unsuccessful, except for the expansion into Canada in early 2012.

Both parties announced that the transaction is scheduled to be completed by March 2013 and will be subject to approval by shareholders and the respective regulatory bodies.

Managing Director of Bupa Australia and New Zealand Dean Holden commented that the acquisition will help his company to strengthen its existing health care offering and support it in its aim to become a health care partner to more customers worldwide. Bupa, which is based in the UK, provides private medical and dental insurance and health services to ten million customers in Europe, Asia and Latin America.

Dental Corporation Holding currently maintains 190 dental offices with more than 450 dentists throughout Australia and New Zealand. During the last fiscal year, the company reported revenue of AUS$359 million (US$355.3 million), which makes it the largest provider of private dental health care services in both markets.

Fortis Healthcare Australia is held by Fortis Global, a US$1 billion enterprise founded by brothers Malvinder and Shivinder Mohan Singh from India in 1997. They formed the company late in 2001.

Sing dental provider Q & M makes takeover bid for SMG

DT Asia Pacific

SINGAPORE: In an effort to extend its health care offering, Singapore’s largest provider of private dental services, Q & M, has announced its intentions to buy a majority stake in Singapore Medical Group (SMG), a specialist medical provider operating 15 health centres throughout the city state.

The proposed deal, estimated to be worth more than S$222 million (US$17.8 million), is expected to be completed in mid-2013 and could add 80,000 customers to Q & M’s customer base of almost half a million patients.

Following the announcement, SMG shares on the Singapore stock exchange jumped by 60 per cent last week. Established in 2005, the company currently maintains clinics specialised in eye and cancer treatment, as well as in orthopaedics and aesthetic surgery. For the last fiscal year, it reported a net operating profit of more than S$1 million (US$150,000).

Q & M CEO Dr Ng Chin Siau commented that with the proposed takeover, his company aims to benefit from the increasing demand for high-quality health care services in Singapore and the South-East Asia region. He said that after the acquisition has been finalised, Q & M intends to open a number of general medical practices in the near future that will offer comprehensive and holistic medical services in addition to SMG’s existing facilities.

“The existing team and viable operational structures within SMG give us a good start,” Siau said.

Q & M operates a few dozen dental clinics and practices in countries like Singapore, Malaysia and the People’s Republic of China. According to financial reports, the group and its subsidiaries achieved a revenue of S$520 million (US$50 million) last year.

APDN and LADN no longer published

DT Asia Pacific

SINGAPORE: Owing to difficult market conditions, UBM Medica, a subsidiary of B2B communications provider UBM in the UK, has announced the closure of its dental publications for Asia and Latin America with immediate effect.

Both titles Asia Pacific Dental News and Latin American Dental News (America Latina Nutricion Dentales) have been suffering from declining advertising revenues and rising costs, the Singapore-based publisher told partners and suppliers in an e-mail recently obtained by Dental Tribune Asia Pacific.

Existing agreements with advertisers and suppliers will be terminated according to the terms of the contracts.

Major market players offering dental CAD/CAM systems and solutions in China include Sirona Dental Systems, KaVo and AmannGirrbach.

First held in 1994, DenTech China has become the second-largest dental showcase in China, after Sino-Dental in Beijing, having attracted more than 65,000 visitors this year. Since March 2012, the show has been organised by Shanghai UBM ShowStar Exhibition, a joint venture between UK-based B2B communications provider UBM and the previous owner of DenTech, Shanghai ShowStar Exhibition Services.

The 17th exhibition is scheduled for 23 to 26 October 2013.

The last edition of APDN appeared in December 2012.

Asia Pacific Dental News has been published quarterly since 1986.

Tursten R. Oermus, publisher of Dental Tribune Asia Pacific, one of now two remaining regional dental publications in Asia, expressed regret at the closure of one of the region’s oldest dental publications. He said that despite the tough economy, Dental Tribune’s monthly title, published in English since early 2002, is going strong and will continue to provide independent regional and international news to Asian dental professionals for years to come.

DTI currently maintains publishing operations in over 90 countries, including general interest and specialty titles, as well as a number of news and CE websites.
Restorative offering by Ultradent

KUALA LUMPUR, Malaysia: With UltraSeal XT hydro, Ultradent has a proven dental sealant with hydrophilic properties in its portfolio that allows the clinician to pretreat a tooth without the need for a drying agent. According to the US company, owing to the advanced adhesive technology used in UltraSeal XT hydro, the product bonds securely to enamel, reduces microleakage and increases marginal retention, resulting in fewer patients who need sealants replaced. Available in natural and opaque white shades, UltraSeal XT hydro fluoresces under a black light, a feature that aids the checking of retention at the time of placement and during subsequent visits. In addition, light curing is intended to be more accurate and efficient with VALO, awarded best polymerisation lamp by US testing institute REALITY in 2010. Available as a corded and cordless model, this durable unibody device, made of scratch-resistant aerospace aluminium, offers clinicians three power modes (Standard, High Power and Xtra Power) for higher treatment versatility. Owing to its sleek design and focused columnar beam, access to all areas of the oral cavity has been improved significantly, the company said.

Since 2011, Ultradent has been providing support and training to its customers in the Asia Pacific region through its headquarters in Malaysia. The manufacturer also recently expanded its operations in Australia and New Zealand through a new distribution agreement with local dealers Gunz Dental and Henry Schein.

A-Dec LED Light

NEWBERG, USA: US dental manufacturer A-dec has announced that its award-winning A-dec LED light is now also available to existing A-dec light users. Clinicians who have a working flexarm on an A-dec light manufactured after 1993 will be eligible for the upgrade, which is claimed to provide 20 per cent more luminance at one-fifth of the power needed for halogen bulbs.

With an A-dec LED light, clinicians have a brilliant white light with a colour index of 90 at 5,000 K at their disposal, which according to A-dec allows them to see colours more accurately for a better diagnosis, reduces shading and improves contrast. The cure-safe mode provides brilliant yellow light at 25,000 lux intensity, enabling the dental team to work effectively without curing photoinitiated resins.

The A-dec LED light can be positioned with three axes of rotation and 540 degrees of horizontal motion, resulting in optimised ergonomics for the entire dental team and improved patient comfort. The on/off function turns the dental light on automatically when the chair reaches the treatment position and turns it off in the entry/exit position when used with the A-dec 500 and A-dec 500 systems.

Switching modes can be done locally or via a remote touchpad, the company said.
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HIV screening and testing in the dental setting

Drs Stephen N. Abel, Carrigan L. Parish & Lisa R. Metelch

Worldwide, there are approximately 34 million people living with HIV/AIDS. Globally, 2.3 million people are newly infected annually. Within the US alone, the Centers for Disease Control and Prevention (CDC) estimates that 1.14 million persons aged 13 and older are living with HIV/AIDS, of which 287,000 (18.1 per cent) are unaware of their infection.1

Between 40,000 and 50,000 Americans are newly infected annually, a number that has remained relatively stable over the past decade.2 Studies demonstrate that persons substantially reduce sexual behaviours that might transmit HIV once they are aware of their HIV-positive status.3

With the objective of facilitating HIV screening in order to bring more persons into care and to reduce transmissions ultimately, the CDC released its report titled “Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings”.4 These 2008 recommendations eliminated two major obstacles to rapid HIV testing: the need for written HIV testing consents separate from general medical consents, and the need for providing prevention counselling as a part of the testing process.5

Most recently, the 2012 US Preventive Services Task Force—a medical panel of experts operating under the US Department of Health and Human Services—upgraded HIV testing for all adolescents and adults aged 15 to 65 to an A rating, which is granted to services with the highest strength of evidence and magnitude of net benefit.6 This rating is critical in the context of the Patient Protection and Affordable Care Act, which requires health insurers to cover preventive services that have an A recommendation.7,8

Despite revised recommendations endorsing routine HIV testing across all health-care settings, the actual implementation of routine HIV screening by health-care providers has been slow. Within the academic and AIDS research communities, the dental setting has been discussed as a promising site for rapid HIV test implementation and as a new modality to address this public health concern. While the dental setting is not specifically mentioned by the CDC, many leaders in the dental profession have postulated that the oral health profession is an underutilised resource setting for the delivery of HIV testing and screening.9

Given the very nature and premise of saliva and oral-fluid sampling, the inclusion of rapid oral HIV diagnostic screening in the standard dental examination is a logical extension of routine oral health care in the US.10 In 2003, the US Food and Drug Administration approved OraQuick, a 20-minute HIV diagnostic test utilising oral fluids with reported sensitivity and specificity values greater than 95 per cent and 99 per cent, respectively.11,12

There have been unexplained clusters of false positive results (i.e. lower specificity) reported by the CDC in several urban centres arising from rapid testing with oral fluids; for this reason, every positive rapid HIV test result is considered a preliminary screening result and must be confirmed by either Western blot or immunofluorescence assay testing.13 14 15

Still, since the oral-fluid collection process only necessitates a simple swab of the oral mucosa—as opposed to venipuncture—it is regarded as a less invasive screening method and has therefore demonstrated high rates of acceptability.16 17 18 19 20

While the link between oral-fluid sampling and the dental profession is obvious, it remains inconclusive whether the dental profession is willing to accept HIV screening as an additional responsibility.19 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38

The majority of patients would accept HIV screening as part of their dental examination. (DTH Photo Lucky Business)

The findings suggest that the dental office may be an untapped health-care setting for convenient rapid HIV screening/testing for at-risk and/or asymptomatic HIV-infected individuals at a given time.30 31 32 33 34 35 36 37 38 39 40

Successful, widespread implementation of rapid HIV screening will likely rely on an understanding of patient attitudes, perceptions and willingness to be screened.

Contrary to the belief that patients may not accept an HIV test in a dental setting as suggested in previous studies,26 further investigations have revealed that patients are actually accepting of this site but in some instances prefer the dental environment.30 An 2008 attitude-assessment survey of patients at the Kansas City Free Health Clinic, for example, evaluated their willingness to accept free rapid oral HIV testing in conjunction with their dental appointments.30 The findings revealed that among those patients who responded a large majority (77 per cent) reported a willingness to take the HIV test during their dental visit.
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Furthermore, when asked from whom out of a given list of health professionals they would most prefer to receive an HIV test, the majority reported indifference (62 per cent), while the next most common response was “my dentist” (37 per cent).

A 2012 New York University qualitative study of patients’ attitudes on HIV testing in the dental setting revealed a very similar outcome: 74 per cent indicated that they would accept HIV screening as part of their dental examination, with some citing specific benefits such as convenience. This is critical in light of past studies citing the need for an additional clinic appointment, the logistics and anxiety associated with waiting for test results, and a return visit to the clinic as common barriers to testing.17, 18, 19

Willingness of dentists and patients to accept rapid HIV testing in the dental setting has been demonstrated in these previous studies. However, additional factors influencing dentists’ practice and actual implementation of rapid HIV testing are their knowledge of HIV/AIDS and awareness of current public policy. A 2012 national survey sponsored by the National Institute of Dental and Craniofacial Research of the National Institutes of Health was conducted and distributed to a representative sample of 2,500 dentists to assess their knowledge, attitudes, beliefs and willingness regarding the possibility of offering routine rapid HIV testing in the dental-care setting.20

Dentists’ limited awareness of the innovations in HIV testing and current national policies was evident by the very first question, as less than one-third (32.3 per cent) had even heard of rapid HIV testing before completing the survey. Only 13.8 per cent of respondents were aware of the 2006 CDC revised recommendations for HIV testing in health-care settings. Lack of appropriate knowledge about HIV testing was a common barrier (64.5 per cent), and less than half (60.5 per cent) felt that their clinical knowledge of HIV/AIDS was good or excellent.

With the advent of diagnostic technologies that are timely, reliable and minimally complex, the means to screen patients for HIV rapidly is increasingly becoming the norm. However, despite growing numbers of persons living with HIV/AIDS and no appreciable declines in the number of new infections annually, dentists remain reluctant to incorporate routine HIV screening and testing into their standard examinations and practices.19–21 In order to promote and incorporate widespread rapid HIV screening in the dental setting, focused educational policies for oral health-care providers and their patients will need to be implemented.22

The oral health workforce shares a common patient goal with the primary medical care community: health promotion and disease prevention. It is also at a crossroad. One path will continue to emphasise and prioritise technical expertise; the other will go beyond traditional boundaries with an emphasis on impacting public health in ways presently unrealised.23 The path chosen will ultimately define the profession for the immediate future.24

The oral health workforce shares a common patient goal with the primary medical care community: health promotion and disease prevention. It is also at a crossroad. One path will continue to emphasise and prioritise technical expertise; the other will go beyond traditional boundaries with an emphasis on impacting public health in ways presently unrealised.23 The path chosen will ultimately define the profession for the immediate future.24
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“A good springboard for bringing out the best in every dental school and student”

An interview with Kime H. Cabalquinto, the Philippines, winner of DENTSPLY Asia’s 2011 Student Clinician Program competition in Singapore

Twenty-four-year-old Kime H. Cabalquinto is a dental student at the Centro Escolar University’s College of Dentistry in Malolos, the Philippines. As the first representative of her country, she won DENTSPLY’s Student Clinician Program (SCP) in Asia in 2011. Dental Tribune Asia Pacific had the opportunity to speak with her about the competition, dental education in the Philippines and her plans for the future.

DT Asia Pacific: Dear Ms Cabalquinto, as the winner of DENTSPLY’s Asia Pacific Student Clinician Program in 2011, you recently attended the American Dental Association meeting in San Francisco. How was the trip and what were your experiences of the US and the event in general?

Kime Cabalquinto: I have been to the US several times before but I’ve never been to San Francisco, so I was really excited to visit the place, attend the American Dental Association convention and meet my fellow student clinicians from around the globe.

DENTSPLY was a great host, as always, making sure our needs were met and our expectations exceeded. I made some new friends and together we were able to exchange insights about a variety of subjects—from our research topics to the dental schools that we are from, and even our countries’ rich cultures.

Overall, it was a great and humbling experience. I felt so blessed to be chosen to represent South-East Asia at the prestigious American Dental Association convention.

You won the 2011 DENTSPLY Asia SCP in Singapore with your presentation on okra mucilage extract as an alternative to commercial denture adhesives. Why did you choose this topic, and could you give us more details about your results?

While browsing the Internet for potential research topics, I came across some articles about lawsuits being filed against manufacturers of denture adhesives. Owing to the toxic effects of such adhesives, the complainers were reported to have paralysis of the upper and lower extremities that eventually leads to Bell’s palsy, all of which are due to using a substantial amount of denture adhesive per week.

That was very alarming; something that you put into your oral cavity brings toxins into your whole body over time. And so I thought of looking for an alternative that is not only organic and healthy, but also cost-effective and easily grown. And since I am from a developing country, I also wanted to help my fellow Filipinos who cannot afford to buy the commercially available denture adhesives, much less have a new set of dentures made.

How did you come up with okra?

I hate to admit this but I myself seldom eat okra. It’s because of that gooyey substance that you feel in your mouth while eating it. I don’t particularly like that feeling. When I was thinking about potential plants that may be a suitable adhesive, okra crossed my mind right away. I sought my adviser and mentor Dr Shirley S. Wong’s input on this and she immediately recognised the plant’s potential. So why not put the sticky substance to good use, right?

We tested it on a variety of complete-denture patients in our clinic, and it yielded impressive results on a par with the commercially available ones.

Are you planning to develop this concept further?

We are taking it one step at a time and are currently working on improving the okra adhesive as a product. Despite this, we have already filed a patent at the Intellectual Property Office of the Philippines in Taguig City.

Why did you apply for the SCP in the first place, and what do you think about the competition in general?

In my opinion, the SCP contest is a good springboard for bringing out the best in every dental school and student. We were not limited to certain topics, as the company allowed us to think out of the box, explore and go beyond our imagination. I thought of looking for an alternative to conventional denture adhesives, much less have a new set of dentures made.

How did you come up with okra?

I hate to admit this but I myself seldom eat okra. It’s because of that gooyey substance that you feel in your mouth while eating it. I don’t particularly like that feeling. When I was thinking about already filed a patent at the Intellectual Property Office of the Filipinos in Taguig City.

What are your plans for your professional future?

Right after I pass the dental board examinations, I intend to enrol for postgraduate courses abroad. I wish to be exposed to new techniques and innovations, especially as far as research is concerned. When I am fully equipped with the knowledge, I plan to go back home to the Philippines and share what I have, or will learn, with my colleagues and fellow students.

I want to be a source of encouragement to those who want to pursue research, let them know that all things are possible through hard work, the right motive and faith.
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Use of tilted implants in the treatment of the edentulous posterior maxilla

Prof. Gregor-Georg Zafiropoulos

This case report describes the technique of implant insertion in the edentulous maxillary posterior region at an angle of 55° to avoid a sinus lift procedure and immediate restoration using fixed partial dentures (FPD), e.g. bridges.

Since the introduction of the technique of inserting posterior tilted implants at an angle of up to 55° (in relation to the vertical axis) and the corresponding prefabricated abutments for the treatment of the edentulous maxilla or mandible, implant dentistry has experienced a change in its previously established, conventional surgical and prosthetic thinking (Maló et al. 2005, 2006). With implants inserted in this unorthodox manner, implantation of regenerative measures in the posterior regions of the atrophic and/or partially edentulous maxilla and mandible is avoided, allowing immediate loading and restoration.

Clinical studies show that the success and survival rate of implants inserted at such an angle are comparable to those inserted at a conventional angle (Khatami & Smith 2008; Krekmanov et al. 2000; Freni et al. 2010). Further results demonstrated that there was no significant difference in bone loss between implants inserted with a conventional axis and those inserted at an angle (regardless of jaw and/or region; Zampelis et al. 2007; Francetti et al. 2010).

This implantation technique was developed for the rehabilitation of an edentulous jaw, but only very little information is available about its application for rehabilitation of partial edentulism in posterior regions with FPD (Rocuzzo et al. 2009, Cordaro et al. 2009). This report presents observations made over one year of a representative case, in which the edentulous posterior regions of the maxilla were reconstructed using implant-supported FPDs.

Case report

A 55-year-old male patient (non-smoker) presented himself at the practice of a colleague because of advanced periodontal destruction in the maxillary arch one year before the start of the treatment described in this report (Fig. 1). Teeth 12, 14 to 18, 24 (re-tained root) and 25 to 27 were extracted. The extraction sockets were covered with dPTFE membranes (Cytoplast, Osteogenics Biomedical) with no additional use of grafting material, as previously described (Hoffmann et al. 2008; Zafiropoulos et al. 2010). The mucoperiosteal flap was repositioned and fixed in the region of the papillae using interrupted sutures (Cytoplast, Osteogenics Biomedical). The membranes remained partially exposed and were removed after four weeks. The edentulous areas were then fitted with a model cast prosthesis.

About one year after the extractions in the maxilla, the patient presented at our practice for implant treatment. The patient suffered from bilateral chronic sinusitis and would not allow a sinus augmentation to be performed. Five implants (3.75 mm in diameter and 11.5 mm in length; SoftBone, Dentegris) were placed in regions 12, 14, 16, 24 and 26. The implants inserted in regions 12, 14, 16 and 24 were inserted conventionally, i.e. axially, and an internal sinus lift was performed in region 16 (Fig. 2). The implant inserted in region 26 was inserted at an angle of 55° to the vertical axis and immediately provided with a 55° titanium abutment (DAAS abutment 55°, Dentegris). An impression was taken using system-specific impression posts (pickup posts were used for the axially placed implants and DAAS posts for the tilted implants, both Dentegris) and a polyether impression material (Impregum, 3M ESPE; Fig. 4). The implants were then provided with system-specific healing caps (Dentegris; Fig. 3). Three days after implantation, transfer keys were used to fit individual abutments. To fabricate the individual abutments, platinum/titanium/plastic abutments (PTIR abutments, Dentegris) were used. On the same day, both a metal framework made of a cobalt-chromium alloy (ZENOTEC NP, Wieland) and a temporary restoration made of plastic (ZENO-PMA, Wieland) were milled for immediate restoration of implants 14 to 16 and 24 to 26. The framework was fitted and the temporary restoration was fixed using a temporary cement (TempBond, Kerr; Figs. 6–11). Four months after implant placement and progressive immediate loading with the long-term temporary restoration, the final restoration was fitted using a temporary eugenol-free cement (Implant-Provisional, Alveolog; Fig. 12).

Conclusion

Under certain conditions (no active periodontal disease, good patient cooperation, good bone quality, successful early or immediate loading of implants in the posterior maxilla is possible in selected cases. Primary stability and implant design play a major role in the success of the implantation and restoration/ loading of bridge restorations on...
On the basis of the scientific results published to date, it is not possible to discuss evidence-based contra-indications (based on the required and measurable values of primary stability, bone density and quality, and influence of occlusal forces). As a result, many questions remain unanswered and risks uncertain (Roccuzzo et al. 2009).

In our opinion, the primary benefit of using tilted implants is not necessarily the option of immediate implantation and loading, but firstly the avoidance of augmentative measures (e.g. sinus lift) and secondly treatment with a fixed restoration (Rosén & Gynther 2007; Aparicio et al. 2001). Regardless of the many positive scientific reports, the dentist should be aware of the risk of implant loss associated with immediate implant placement and loading. In addition, the dentist should define his/her own limits and select patients based on strict criteria.

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

References

Contact Info
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In addition to its elegant and stylish design, its ease-of-use, its high image resolution and its reliability, the I-Max Touch 3D offers the ideal field of view (FOV) for use in dental imaging. With SimPlant® software pre-loaded, the I-Max Touch 3D is a MUST-HAVE for your implant planning procedure.
In aesthetic dentistry, it is essential not only that the patient's beautiful smile be restored, but also that the restoration be lasting. The advances in adhesive technology have encouraged clinicians to use composite resin for the replacement of missing tooth structure. Modern dentistry offers a wide array of different materials, techniques and procedure options to satisfy patients' needs.

In mimicking the shade of teeth, dentists attempt to restore what is missing in a natural way. In order to achieve successful treatment outcomes, we need materials that are similar in their light-reflective qualities to the missing tooth structure, that is, the replacement of dentine with a dentine substitute and of enamel with an enamel substitute. This article describes how the various materials can be used to achieve highly aesthetic restorations in the anterior and posterior dentition.

Clinical case

A 15-year-old female patient was seen with toothache, multiple carious lesions and discoloration in the anterior and posterior teeth (Figs. 1 & 2). She had undergone numerous dental procedures in the past and had a history of orthodontic treatment, in which her mandibular first premolar teeth were extracted. The primary goal was to relieve the patient's pain. Therefore, several teeth had to be endodontically treated. Afterwards, the old posterior PFM crowns were removed and replaced with all-ceramic crowns (IPS e.max Lithium Disilicate, Ivoclar Vivadent). In addition, the carious lesions in the posterior region were restored with a direct resin restorative (IPS Empress Direct, Ivoclar Vivadent).

After successfully completing treatment in the posterior teeth, we focused on the reconstruction of the anterior teeth. Having considered all the various restorative options, we opted for direct restorative treatment with composite-resin veneers.

Veneers made from composite resin

Before commencing local anaesthesia, carious tissue was excavated with high-speed diamond burs and low-speed round burs. A flame-shaped diamond bur and coarse finishing discs were used to prepare the fine details in the cervical area and on the labial surface of the teeth. On the labial surface, we reduced only 0.8 to 1 mm to preserve as much natural enamel as possible. A short bevel was prepared at the amelodentinal junction in the cervical region and also in the area of the proximal cavities (Class III preparation).

Subsequently, the prepared surfaces were thoroughly rinsed with water.

As there were Class III cavities, we completed these restorations first (Fig. 3), followed by shade selection. Then, direct veneering with IPS Empress Direct composite material was performed. For this purpose, the prepared maxillary central incisors were etched with 57% phosphoric acid gel (Total Etch, Ivoclar Vivadent) for 15 seconds (Fig. 4). Neighbouring teeth surfaces were protected by covering them with Teflon tape.

After etching, the teeth were rinsed with water and dried, taking care not to dry them to the point of desiccation. Subsequently, the total-etch adhesive ExciTE F was applied using the VivaPen (both Ivoclar Vivadent) and brushed into the enamel and dentine surfaces for ten seconds (Fig. 5). A gentle stream of air was used to disperse the excess into a thin layer. Then the adhesive was light-cured for ten seconds with the Low Power Bluephase 20i. A layer of IPS Empress Direct Enamel A1 was used to complete the labial surface from the middle of the incisal third to the incisal edge (Fig. 6 & 7). The last layer of this veneer restoration was IPS Empress Direct Trans 20 compos- ite, which was applied to the entire labial surface in a thin layer. The final anatomy was sculpted using OptralSculpt and a brush. The same procedure was repeated on the neighbouring tooth.

The proximal contours were carefully sculpted to develop proper areas of deflection and reflection of light, taking care to maintain the symmetry between the right and left maxillary central incisors. The other teeth affected were restored in a similar manner.

After considering the primary anatomy, the secondary and ternary anatomy was crafted using the OptralSculpt modeling and sculpting instrument (Ivoclar Vivadent). After polymerizing this dentine layer, the grooves created between the lobes were filled with a highly translucent ceramic material (IPS Empress Direct Opal) and light-cured for 15 seconds using the Soft-Start mode of Bluephase 20i. A layer of IPS Empress Direct Dentin A2 was placed on the cervical edge (Fig. 8). A translucent wax mock-up on the stone model (Virtual Putty, Ivoclar Vivadent). Once placed in the patient's mouth, it would be used as a spatial reference and 5.5 hours guide for the placement of the composite-resin veneers. After positioning the putty matrix on the teeth, the first layer of composite resin (IPS Empress Direct Trans 30) was placed on the incisal edge and the proximal aspects of the palatal surface (Fig. 9). The putty matrix was finally removed and the cervical area built up with a layer of IPS Empress Direct Dentin A2, extending it to the middle of the incisal third (Fig. 10). Small dentinal lobes were prepared in the still-soft composite resin using the OptralSculpt mod- elling and sculpting instrument (Ivoclar Vivadent). After polymerising this dentine layer, the grooves created between the lobes were filled with a highly translucent material (IPS Empress Direct Opal) and light-cured for 15 seconds using the Soft-Start mode of Bluephase 20i.

After consideration of the primary anatomy, the secondary and tertiary anatomy was crafted using 12-fluted carbide and diamond finishing burs. The Astrobrush finishing burs (both Ivoclar Viva- dent) was used to impart a high lustre while maintaining the previously created surface texture and anatomy (Fig. 11). Astrobrush was used at a low speed without pressure to achieve a high-gloss finish.

Conclusion

Aesthetic restorative dentistry strives to reproduce the natural anatomy, translucency and characteristics of natural dentition. In the clinical case presented, interdisciplinary procedures along with the proper selection of materials helped the clinician to achieve the desired result. The combination of a direct adhesive technique in the anterior region (IPS Empress Direct) and an indirect technique in the posterior region (IPS e.max Lithium Disili- cate) allowed the creation of long-lasting and natural-looking restorations. The patient was extremely happy with her new, beautiful smile (Figs. 11–14).

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Collaborating and connecting in the dental space

Shane Hebel
Lamaha

Communication skills are an integral part of our daily lives. How we communicate defines who our friends are, what our families think of us, and how our businesses are perceived by the community at large. Typically, when you think about communicating, you think about it in relation to your friends and family. We spend countless hours thinking about how we speak to other people, what effect it has on them, whether we should have said something or not, or if other people think we’re upset with them or frustrated based on our words and actions.

Oh wait! Actions. That’s another part of communicating that many people don’t think about. How your body moves in rhythm with the way you’re talking can have a major effect on what people perceive you to be saying. Our bodies and mouths move in a dynamic that we don’t yet really understand, but our subconscious selves do. Have you ever gotten that feeling that even though someone was apologizing to you, they didn’t really mean it? Or that someone was really upset when they told you that everything was fine? Why do you think that you get those feelings? Something about the way that that person is communicating with you—other than with their words—is telling you that.

A second aspect of actions is your actual actions. We’ve all heard the saying “actions speak louder than words”. Well, it’s true. If you say one thing and do something completely different, that’s a form of communicating. If you’re always consistent in the way you approach a problem, or situation, that’s also a form of communicating. How you conduct yourself both personally and professionally is a way to communicate the person you are and what you stand for. The most important part of that is that people actually take notice.

When bad goes good

In 1995, Tylenol had a problem. Many bottles of its medication had been tampered with and would prove to be dangerous or fatal if ingested. Right away, the company recalled its entire product and spent a huge amount of time and money figuring out what went wrong and in making sure that no one became ill—all at the expense of its brand image. The company did the right thing, and stood by its values. Here’s the kicker—while it thought that posting this recall would destroy its company image, it actually bolstered it. People found it extremely admirable that the company was more than willing to tarnish its own reputation and spend huge amounts of money to stand by its values. They stood by Tylanol. Tylanol had communicated to people that it was an ethical company and that communication was heard loud and clear.

Some people and companies don’t care what other people think of them. In fact, some actually thrive on their inability to communicate and the dislike people feel for them as a result. Take Parris Hilton, Lindsay Lohan or Kim Kardashian. These three women are all celebrities who communicate a terrible image and are famous for it. They succeed because people don’t like them and are just itching to figure out what they’re going to do next.

Communicating

However, a terrible image is not what most people (and especially companies) want. People naturally want other people to like them. They want to be seen as people who stand by their values, can get their point across, and can do so without projecting the image of being mean, frustrated or impatient.

As something that many people strive to do, communicating effectively has been discussed extensively in our society. Countless books and programmes have been conducted that deal with communicating with people. Even more books have been written on the subject.

So why is how we communicate so important? Good questions. Awareness of others is important because it gives others an idea of what we think, who we are, and what we stand for. This is extremely important in your personal life. It’s even more important in your professional life. How others perceive you can have a huge impact on how smoothly your office runs, how many new patients you get, and how easy doing business with other people is. Communicating is at the crux of how we function as a society and your ability to function well from a communication standpoint will have huge impacts on your personal and professional life.

One thing that has already been mentioned is how solid communication leads to a smoother internal business process, bringing in more patients (or retaining returning patients), and working together more efficiently with others in the dental space.

How?

Let me break each of those aspects down for you to show how increased communication skills can help you in each of those areas.

The first major area that is going to affect how you communicate is your internal business processes. How you communicate internally within your office can have a huge impact on how smooth your operations are, how happy your staff are, or even what your monthly expenses are. All of these things can be improved by communicating more efficiently and effectively within your organization. Huge mistakes can be made in business through a failure to communicate or a lack of understanding among team members. Take Morgan Stanley as an example. Recently, they made a US$2 billion blunder that has led to increased surveillance of all US banks by the government, an investigation into the company, a huge drop in their stock price, and the resignation of some of the top performers and managers at the company. Why was this mistake made? Someone messed up because of a lack of communication.

Think about how you communicate with others within the office on a daily basis. The key is to recognize that not all communication is verbal. Reflect on how information is processed, received, transformed, and stored within your company. Then reflect on whether those processes are effective. How is everything being communicated the way it should be. With patients, think about how your reception staff come across. Do patients generally have a good sense of what they’re getting into when they come to your office? Are they aware of the procedures and processes? Do they ever seem confused? Ask yourself these questions and consider asking patients how they feel about your office. If you’re not communicating what you’d like to with your patients, there are definitely things you could tweak in order to be more effective on that front.

There is a well-known theory in the business-marketing world regarding how information is communicated in a business context. Let’s say you have a certain concept you want to communicate to someone. You communicate it to them. They hear a certain concept and act upon it. Those are the three main parts of the communication of a message. The interesting thing is that the message that you intended to communicate is not always the same message that is received. How closely these two align is determined by the medium and mode of communication that you use. Information can be communicated in a variety of ways within the office. Let me review some of the more common ones briefly.

In person

Offices are fast-paced environments and, frankly, written communication is slow. One of the most common forms of communication in the office environment is oral communication. Speaking with your reception staff, hygienist, or assistant is usually the fastest way to get information across. However, there is one problem with relying on oral communication alone—it’s notoriously unreliable. People mumble, mishear things, tune-out, don’t generalize and forget. Oral communication...
can thus lead to misunderstandings moreso than any other form of communication. Another con-
erm is that oral communication isn’t recorded. Unless someone writes down what is said, there
is no record of it. This can play havoc in internal work relationships and can lead to an inef-
factive process in some cases. Of course, there are times when oral communication works bet-
ter than anything else (for example, in the operating room), but there are a number of cases in which oral communication should be converted to something more permanent or at least more written down. An example would be ask-
ing your reception staff to refer a patient to a specialist. If the re-
quest is made orally, staff may forget, the doctor may think that he’s made the request when he
didn’t, and the request could fall through the cracks of the endless stream of office paperwork.

An alternative may be to use e-mail or have a written note taken on the spot. This is just one example of how communication in your office could be made more efficient. It also leads us to the next type of office com-
munication.

Written communication

Written communication can take on many different forms. Paper
notes, e-mails, faxes, various feedback and consent forms, and even Post-it notes are all exam-

ples of written communication that you may see in your office space. Unlike oral communica-
tion, written communication is more permanent and provides a record of what was communi-
cated throughout the office, making it a desirable communication form. The only problem with it is that it’s slow and can easily be misinterpreted. Messy handwriting, short-forms, and

absence of tone in language can all lead to a written note being misinterpreted. How-
ever, this happens far less often than with oral communication because there is a paper trail.
People can ask for clarification, check things that happened pre-
viously, and gain a better sense of what the note is about from sup-
porting documents, other staff or other notes. This is the form of communication desired for
most official communication. Staff records, patient records, to-do lists, etc. are typically all in
a written format because they can then be tracked.

So what do you want to keep in this type of format? You want to write down anything that you want to be able to refer back to at
a later date. A not-so-formal type of thing that you may want to consider using is writing down what oc-
curred in meetings with office staff. This will allow you to look back at what was discussed, what
items are outstanding, and what you should expect at an upcoming meeting. None of our memories is
perfect and writing things down is a huge help in keeping records and helping your practice to run
more smoothly.

“...not all communication is verbal.”

Body language

The third type of communi-
cation (and possibly the most
important) is what your body
language/appearance and that
of your staff says. While not explicit,
what your body says can have a huge effect on how people per-
ceive you, what people think of what you say, and even whether people believe what you’re say-
ing to them. There isn’t much to be said about body language other than to be aware of how you’re coming across to others and whether there is anything that you’re doing that you could change that would make you

appear more genuine, approach-
able, honest, or any other quality
that you wish to demonstrate. In terms of appearance, do you seem approachable and trust-
worthy? Do you present yourself in a professional manner? Do other people think that you come
across as someone to respect? These are all questions that you can ask yourself that deal with
your body language and how you

present yourself to other people. This matters in all of the interac-
tions that you make—with your staff, clients and partners.

Collaborating

Now that you’re aware of the
different types of methods of
communication, there is one
more area in which they can be
applied that can result in huge
changes in your business: collab-
oration with others. When most
people think of collaborating and
working together, they think in-
ternally. Most will think about
working together with their fam-
ily or with your office staff. Very
few think about how they can
 collaborate with others outside
of their immediate circle. Yet, this
type of collaboration can have a
huge impact on your business.
Throughout business history,
companies have collaborated in
to order to come up with big ideas
and profitable ventures. Think
about Sirius Radio; that’s a com-
pany that knows collaboration.
It only really took off after collab-
orating with car companies and
having the system installed into
cars before they left the sales
floor.

By working together, partici-
pating car companies got a new
gadget to use to entice buyers
to purchase their vehicles and
 Sirius Radio got access to a brand
new market that proved to be
extremely profitable.

Collaborating and communi-
cating go hand in hand. If you’re lacking in how you communicate with others, your ability to col-
laborate with others will also
be lacking. Collaboration is all
about working together with oth-
ers, as you can change things
that are, and generally make your practice more effi-
cient both internally and in the
image that is presented to the
outside world. Decide what you
want to communicate as your brand and start doing it!

Conclusion

Always be aware of how you’re communicating with other peo-
ple and always be looking for opportunities to collaborate. Simply being aware can do won-
ders, as you can change things that aren’t working, enhance things that are, and generally make your practice more effi-
cient both internally and in the
image that is presented to the
outside world. Decide what you
want to communicate as your brand and start doing it!

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Edelweiss precured composite veneers are laser sintered, giving them better durability and scratch resistance. Combining this proprietary technology with affordability, Edelweiss unlocks the opportunity for dentists to give more patients the long-lasting, esthetic smiles they’ve always wanted—at a price they can afford.

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