Emirates Dental Hygienist Club welcomes over 40 dental hygienists during inaugural event at CAPP Training Institute

By Emirates Dental Hygienist’s Club

The Emirates Dental Hygienist’s Club (EDHC) held their inaugural Annual Symposium on Friday 19th January at Centre for Advanced Professional Practices (CAPPmea) CAPP Training Institute facilities in Dubai, UAE. President Rachael England welcomed over 40 dental hygienists from throughout the region and began proceedings with a lecture on the role of the EDHC to empower clinicians, improve health literacy in the region, develop interdisciplinary collaborations and the need for public and private sector partnership.

Discussion included public health in a dental context, presented by Rachael England, providing an uplifting speech about the role of the Dental Hygienist within public health, followed by opportunities and challenges to improving oral health in the UAE region. Continuing the public health theme, Dr. Shiamaa Shihab Al Mashhadani of the Dubai Health Authority presented her inspiring work on the “My Smiles” initiative, demonstrating the effectiveness of early life intervention and oral health education for 4-6-year-olds. The initiative is fully covered by Dental Tribune MEA in the January-February 2018 publication.

Mary Rose Pincelli Boglione of the International Federation of Dental Hygienists (IFDH) was delighted to join the club for the day and provided an insightful presentation based on “When is the best time to brush?”. Next up was an interactive session held by Beverley Watson updating the attendees with the latest techniques in guided biofilm removal, followed by further discussion about management of biofilm using oral probiotics by EDHC treasurer Joanne Flower.

The EDHC welcomed Dr. Hamzeh Awad, Associate Professor in Health Sciences and Health Information Technology Abu Dhabi University, supported by EDHC Vice-President Hanan Abdallah, to present the innovation of telemedicine and diabetes management and questioned the attendees how they would embrace this technology to support their own patients, providing the opportunity for future collaboration.

Dr. Eleftherios Kaklamanos, Associate Professor in Orthodontics, closed proceedings with a dedication to teamwork between Orthodontists and Dental Hygienists, reinforcing the essential role Hygienists play in preparing and maintaining patients throughout treatment.

President Rachael England commented “Ongoing events are planned throughout the year to continue providing educational opportunities and professional support. Along with community health initiatives, starting on World Oral Health Day, 20th March 2018.”

A special thank you was made to CAPP, Philips/Jordan and Oral B/Crest for their support of this event and ongoing activities the EDHC have planned. Dental Hygienists who are interested to join the EDHC are encouraged to contact the club directly through the official website.

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One of the primary ways in which oral health can impact the quality of life are the socio-economic costs. In Europe, traditional curative treat- ment accounts for 5–10 per cent of total public health expenditure. The Platform for Better Oral Health in Europe forecasts that the total cost will rise from €44 billion in 2000 to €93 billion in 2020. Oral diseases are the fourth most expensive to treat, according to the World Health Or- ganization, and this financial aspect can hinder people of lower socio- economic standing in receiving ap- propriate care.

The prevalence of caries and other oral diseases is a worrying trend, especially given the increased knowledge of how oral health can be maintained through twice-daily brushing with a fluoride toothpaste, a healthy diet and regular den- tal check-ups. In the Netherlands, for example, a commonly implemented programme to prevent caries among children involves twice yearly check- ups that are often accompanied by an application of fluoride and the sealing of all visible fissures. This pro- gramme is covered by the country’s health insurance and is thus free for all children up to 18 years of age, ensuring that there is no financial disincentive. In spite of this progress- ive and egalitarian approach, the proportion of Dutch youths with- out any caries experience has not dropped over the last 30 years and has remained stable.

It was clear from this that an alterna- tive approach to caries prevention needed to be tested. Working from the basis of a study conducted in Denmark, a group of dental research- ers in the Netherlands trialled a non- operative caries treatment and pre- vention programme with a pool of 6-year-old children. This programme, which promoted recall intervals based on individual risk assessment, resulted in a 40–70 per cent reduction in caries for the group subjected to the NOCTP method.

Prevention spoke with Corrie Jong- bloed-Zoet, President-elect of the International Federation of Dental Hygienists (IFDH), about how the principles of these scientific stud- ies are applied to a programme implemented by Dutch society for the promotion of oral health ‘Ivoiron’ and ‘Ivory Cross’ and the impact these studies may have on approaches to caries prevention throughout Europe.

What are the principles upon which the NOCTP approach is founded, and how do these differ from conventional caries prevention approaches? NOCTP is based on individual risk as- sessment, extensive oral hygiene in- struction and education, and paren- tal home care. In contrast, we have the regular (Dutch) protocol that is based on dental check-ups twice a year, fluoride application and seal- ants and if necessary restoration of caries on the dentine threshold.

The protocol is based on the under- standing that caries is a localised process that can be prevented by brushing with a fluoride toothpaste. Extensive oral hygiene instruction and education are given and recall intervals are made on an individual basis using the following criteria: the cooperation of the parents, the activity of carious lesions within the dentition, the eruption stage of per- manent molars and carious activ- ity affecting the occlusal surfaces of the first permanent molars. Unfor- tunately, we see a great deal of very progressive carious activity in pri- mary dentition and in first molars, especially among young immigrant children and in lower socio-econom- ic income groups.

Could you please take us through the protocol of the Ivoiron Knuijs’ Gewoon Gaat programme? The first appointment is made with a dentist or a dental hygienist and is followed by a demonstration of vis- ible plaque and education and train- ing in plaque removal by the patient and motivational interviewing. After professional plaque removal, a dia- gnosis is made and the treatment continued. In the case of no caries progression, a risk and interval as- sessment is determined. In the case of caries progression, treatment, education and training are followed by fluoride application, sealing or restorations.

Step 1 During the first visit, the patient and his or her parents are informed about the programme and asked about their motivation to partici- pate, problems, previous experienc- es, fear, stress, etc.

Step 2 After disclosing of the plaque, the level of oral hygiene and self-care is noted—plaque index—followed by information and instruction. The pa- tient or his or her parent is asked to remove the plaque him- or herself.

Step 3 The next step in the NOCTP protocol is professional cleaning.

Step 4 A very important factor for risk as- sessment is the diagnosis of carious activity: small pits and severe caries

Step 5 The next step is motivational inter- viewing, which is the key to success. The patient is prepared for imple- menting change and this might need multiple sessions. If the pa- tient is ready to change, he or she is instructed—through explaining, showing and doing—and motivated and coached, with the intention that he or she will change his or her atti- tude towards oral health and his or her behaviour.

When it comes to the pre- vention of caries in children, what role do parents’ atti- tudes play? The programme focuses on behav- ioural change: the patient and/or his or her parents are encouraged to take responsibility for his or her oral health. In the study, the par- ents’ attitude turned out to be a de- cisive factor. There are parents who are conscious and responsible, but there also parents who are trivialis- ing and fatalistic, appearance-driven and open-minded, knowledgeable but defensive, or conscious and con- cerned. The health care providers are trained over several days to be fa- miliar with these differences and to consider them in their approach to- wards the patient’s parents. After in- formed consent has been obtained, parents are asked to fill in a ques- tionnaire to provide information on socio-economic circumstances, oral hygiene habits, oral health history, dietary habits, self-care routines and knowledge on dental topics.

What role does the IFDH play in the promotion of oral health in Europe? The IFDH is an international non- governmental organisation reg- istered in the US and unites dental hygienist associations from around the world (52 countries) in their com- mon goal of promoting oral health and preventing oral disease. The fed- eration represents approximately 85,000 dental hygienists. All Euro- pean countries where dental hygien- ist associations exist are members of the IFDH and of the European Den- tal Hygienists Federation (EDHF). The IFDH and EDHF work together towards their common goal of im- proving oral health worldwide with partners like the Alliance for a Cavi- tity Free Future, the Global Child Den- tal Fund and the European Platform for Better Oral Health in Europe.

References

By DTI

“Prevalence of caries and other oral diseases is a worrying trend”

Interview with Corrie Jongbloed-Zoet on caries
NEW COLLECTION

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Curaden believes in prevention like no other company in the world

By Ueli Breitschmid, Curaden

When Dental Tribune approached us with the idea of a new magazine on the topic of preventive dentistry, I thought: “Well, it’s about time! You should have done this a while ago!” For those who don’t know me, I often like to speak from the heart and the dental industry lies very close to my heart. I’ve been in the business my entire life and I’ve been the CEO of Curaden AG for 40 years. Curaden produces oral healthcare products, such as the famous CS 5400 toothbrushes, through our brand CURAPROX. We also provide many educational programmes, such as iTOP (individually trained oral prophylaxis). I am so proud to be a part of such a forward-thinking company, since I truly believe that no mouth will ever change without the use of the right instruments and proper education.

At Curaden, we are proud to manufacture all our products in Switzerland, since the Swiss are known for their high quality, perfection and precision. Yet I was disappointed to hear that one in every three dental students in Switzerland leaves dental school before their graduation. There is no other field of study that experiences such a high dropout rate! What’s surprising is that the overwhelming majority of dental students do not simply drop out. The numbers are as high in Switzerland and many other places in the world, which limits the number of university applicants is very high for human medicine. Also, prospective students for both dentistry and medicine have to pass an admission test in order to study. However, admission is not only easier for dentistry; both medical and dental students spend their first semesters in the same classroom, learning the same things. That’s why pre-clinic dental students who are more interested in becoming medical doctors, can easily take the available spaces of medical students who drop out. This situation leaves me with two questions: why do we not start educating dentists as medical doctors of oral health? And, why don’t we consider dentistry as another medical discipline that works closely with cardiology, otolaryngology and other specialist fields?

Until now, we have educated dentists to become “tooth-repairers”. Dentists learn to place implants in the most difficult positions possible, they learn how to perform endodontics in the most severely curved canals, but when do they learn how to educate their patients on oral health? When will we understand that a healthy mouth is about more than just clean teeth? And when will we understand that our mission should be to keep patients healthy for a lifetime by providing them with the right products and education?

Of course, as a dental industry, we still need to sell toothbrushes, interdental brushes and mouthwashes. Many other companies in the dental industry need to sell implants, endodontic files and drills. Essentially, all manufacturers, dealers and dental professionals still need to look at remaining profitable or increasing profits. And there is no doubt that as an industry, we will still need to repair. Fortunately, our restorations have improved and can now last forever, but our preventive care can definitely be improved.

Mind the trends

The demand for preventive care has rather recent roots. Firstly, the megatrend of having a healthy lifestyle has now also moved into oral care. People want better oral prophylaxis, beautiful teeth and fresh breath. Oral care, however, is about so much more than oral hygiene. Healthy teeth and gums go hand in hand with a good morale and can also lead to healthy bodies. Essentially, the desire for a healthier lifestyle has created a demand for new products and new approaches to provide the patient with oral healthcare services in dental practices.

Secondly, scientists have discovered that oral health conditions have a major impact on people’s general and mental wellbeing. Oral health
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Tap water good for teeth but may cause higher blood lead levels

By DIT

CHAPEL HILL, N.C., U.S.: American children and adolescents who drink tap water, which is typically fluoridated, are much less likely to have tooth decay, according to a new study. However, researchers have confirmed that those who consume tap water are more likely to have elevated levels of lead in their blood compared to those who primarily drink bottled water.

Drs. Anne Sanders and Gary Slade, of the Department of Dental Ecology at the University of North Carolina in Chapel Hill, analyzed a nationally representative sample of nearly 16,000 children and adolescents aged two to nineteen years old, who participated in the National Health and Nutrition Examination Survey (NHANES), from 2005 to 2014. More than 12,000 records included data on blood lead levels and about 3,500 contained dental examiners' data. NHANES is the U.S. benchmark for the national surveillance of blood lead levels and is the sole national source of dental examination data.

Following an at-home interview, participants visited a mobile examina-
tion center where they donated a blood sample, completed a dietary interview and underwent a dental examination. An “elevated blood lead level” was defined as having at least three micrograms of lead per deciliter of blood. “Tooth decay” was defined as the presence of one or more tooth surfaces that are affected by dental caries, as determined by dental examiners using a standard-
ized protocol.

According to the results of the study, children and adolescents who did not drink tap water (about 15 per cent) were more likely than tap water drinkers to have tooth decay, but were less likely to have elevated blood lead levels. Those who drank tap water had a significantly higher prevalence of elevated blood lead levels than children who did not drink tap water.

Overall, nearly 5 per cent of children and adolescents had elevated blood lead levels and almost 10 per cent had tooth decay. Among American children and adolescents, one in five living below the federal poverty level, one in four African Americans and one in three Mexican Americans do not drink tap water—vastly exceed-
ing the one in twelve non-Hispanic, white children who do not.

“Elevated blood lead levels affect only a small minority of children, but the health consequences are profound and permanent,” explained Sanders. “On the other hand, tooth decay affects one in every two children, and its consequences, such as toothache, are immediate and costly to treat.”

The study's statistical analysis also took into account other factors that could account for the relationship between the non-consumption of tap water and blood lead levels and tooth decay. A limitation of the study was that the fluoridation sta-
tus of the participants' tap water was unknown, therefore the observa-
tion that drinking tap water protects against tooth decay may be an under-
estimate of fluoride's protective effect.

“Our study draws attention to a critical trade-off for parents: children who drink tap water are more likely to have elevated blood lead levels, yet children who avoid tap water are more likely to have tooth decay,” commented Slade. “Community wa-
ter fluoridation benefits all people, irrespective of their income or abil-
ity to obtain routine dental care. Yet, we jeopardize this public good when people have any reason to believe their drinking water is unsafe.”

Public awareness of the hazards of lead-contaminated water has in-
creased since 2014, when concerns were raised after the drinking wa-
ter source for Flint in Michigan was changed to the untreated Flint River. A federal state of emergency was declared and Flint residents were instructed to use only bottled or fil-
tered water for drinking, cooking, cleaning and bathing.

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\(\ast\) When toothpaste is directly applied to each sensitive tooth for 60 seconds.

\(\dagger\) Containing 5% potassium nitrate and 1450 ppm fluoride as sodium fluoride.

\(\ddagger\) Containing 1450 ppm fluoride as MFP.

**References:**
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