In cooperation with the Faculty of Dentistry at the Royal College of Surgeons in Ireland

Ajman University Organized a Joint Accredited Dental Conference

In its quest to promote innovative medical environment, the College of Dentistry at Ajman University of Science & Technology (AUST) and the Faculty of Dentistry of the Royal College of Surgeons in Ireland (RCSI), in collaboration with the Dental Society of the Emirates Medical Association, have organized a multi-disciplinary dental conference themed, “Advancing Excellence in Dental Care.”

The two-day event has kicked off Sunday 4th April at the Sheikh Zayed Centre for Conferences and Exhibitions, under the patronage of His Highness Sheikh Mohamed bin Rashed Al-Maktoum, Vice President of the UAE, and H.H. Sheikh Khalifa bin Zayed Al Nahayn, President of the UAE, and H.H. Sheikh Mohammed bin Rashid Al-Maktoum, Vice President of the UAE and Ruler of Dubai.

It is our three dimensional vision – education, information and investment - that has enlightened our endeavors and contributed to the institution’s achievements so far,” said AUST President, Prof. Abdul Azim Ahmed. AUST College of Dentistry, he explained, “was the first of its kind in the UAE when it began offering accredited programs in the year 2000. Since that time it has succeeded in fulfilling dozens of projects and initiatives in academia, and serving the community by providing oral care to more than 100,000 patients.”

Prof. Abdul Azim Ahmed, Chairman of AUST Innovative Medical Environment Commission welcomed the participants saying that “The conference is the fruition of the endeavours of both AUST’s IMEC and CoD, in implementation of the Reform and Development Plan, devised by the University’s higher administration.”

The two-day event has kicked off Sunday 4th April at the Sheikh Zayed Centre for Conferences and Exhibitions, under the patronage of His Highness Sheikh Mohamed bin Rashed Al-Maktoum, Vice President of the UAE, and H.H. Sheikh Khalifa bin Zayed Al Nahayn, President of the UAE, and H.H. Sheikh Mohammed bin Rashid Al-Maktoum, Vice President of the UAE and Ruler of Dubai.

It is our three dimensional vision – education, information and investment - that has enlightened our endeavors and contributed to the institution’s achievements so far,” said AUST President, Prof. Abdul Azim Ahmed. AUST College of Dentistry, he explained, “was the first of its kind in the UAE when it began offering accredited programs in the year 2000. Since that time it has succeeded in fulfilling dozens of projects and initiatives in academia, and serving the community by providing oral care to more than 100,000 patients.”

Prof. Abdul Azim Ahmed, Chairman of AUST Innovative Medical Environment Commission welcomed the participants saying that “The conference is the fruition of the endeavours of both AUST’s IMEC and CoD, in implementation of the Reform and Development Plan, devised by the University’s higher administration.”

The College of Dentistry in Ajman University of Science and Technology has organized a tribute ceremony for Dr. Rahgad Hashim, Assistant Professor and the Head of the Growth & Development Department at the College of Dentistry for her prize-winning of the best scientific research of faculty members in Arab universities on dentistry in 2009.

The research was themed the relation between children oral health and eating habits. The prize is awarded by the Union of Arab Universities in Association with the Arab Colleges of Dentistry in Beirut, Lebanon.

It is worth noting that Dr. Hashim had been awarded many prizes before, to name but a few, she came first in Al-Owais Award for Studies and Scientific Innovation in 2005 for the best research on health and medical sciences in the UAE, entitled the health and environmental condition of the children in Ajman. She also won Colgate Award after presenting her work at the International Association of Dental Research (IADR) conference held in Washington, USA in 2005. During her presence at another IADR conference in New Orleans, USA, Dr. Hashim had one of her researches been nominated for the Giddon Award in 2007.
of prominent and experienced professionals in this field.

In the address of the dean of the Faculty of Dentistry at the Royal College of Surgeons in Ireland, Prof. Patrick J. Byrne expressed his thanks to Ajman University for organizing the conference and for bringing together eminent speakers and participants from around the world. Prof. Patrick, who praised the existing partnership between the RCSI and AUST, briefed the participants on the objectives of the conference, saying that: “keeping up with the literature and evidence of best practice in one area of dentistry alone is onerous, but keeping up with the whole spectrum of modern dentistry may seem almost impossible. We hope that in the two days you will spend with us in Ajman University, we will be able to assist you with that task.”

Dr. Salem Abu Fannas, dean of AUST College of Dentistry welcomed AUST guests and extended his appreciation to Dr. Patrick Byrne and his team from the Royal College of Surgeons in Ireland, Prof. Malcolm Harris from the University of Central Lancaster, as well as Dr. Aisha Sultan, president of the Dental Society of the Emirates Medical Association for their support to this event which has brought together leading academicians and clinicians. This conference will promote research and place our students in an international arena to mix with well-established masters of Dentistry as a Science and as a Profession,” Dr. Salem said.

Dr. Tahal Al Harbi, Orthodontist, Qatar
Dr. Mohammad H. Al Jishi, Bahrain
Dr. Lara Baiakaei, Periodontology, Jordan
Dr. Aisha Sultan, Periodontist, UAE
Dr. Kamal Balaghi, Aesthetics, Iran

President/CEO Yaser Alawi
y.alawi@dental-tribune.com
Director mCME: Dr. D. Mollova
info@mcme.com
Marketing manager Khawla Najib
khawla@dental-tribune.com
Production manager Hussain Alvi
dentalme@dental-tribune.com

Published by Education Zone
in licence of Dental Tribune International GmbH
© 2010, Dental Tribune International GmbH. All rights reserved.
Dental Tribune makes every effort to report clinical information and manufacturer’s product news accurately, but cannot assume responsibility for the validity of product claims, or statements made by advertisers. Opinions expressed by authors are their own and may not reflect those of Dental Tribune International.

Dr. Jon Årtun, DDS, PhD, Dr Odont
Acting Program Director & Prof. of Orthodontics
Advanced Orthodontic Training Program

Dr. Christer Dahlin, DDS, PhD, Dr Odont
Director of Implantology Program
Professor in Oral & Maxillofacial Surgery

For more information: Tel.: 0097143624788

Abu Dhabi Headquarters
Admission Office:
Al Oddah Office Tower, Airport Road, Abu Dhabi, UAE
11th Floor, Office 1201
Telephone: +971 2 404 7141

Fax: +971 4 362 4793
PO Box: 53382, Dubai, UAE
Website: www.abudhioffice.com

Dubai Branch
Dubai Healthcare City
 Ibn Sina Building (No. 27)
Block D, 3rd floor, Office 302
Telephone: +971 4 3624787

PO Box 214592, Dubai, UAE, Tel +971 4 591 0257
Fax +971 4 566 4512 www.dental-tribune.com
Discover Your
Smile Potential
with BEYOND™ whitening products!

Our next generation
whitening system
the future of power teeth
whitening has arrived!

Professional Whitening System
Take-home tray whitening available through
the dental office
- One hour a day for 14 days - no messy overnight whitening
- Visibly whiter teeth in five days
- Gentle hydrogen peroxide formula minimizes risk of sensitivity
- Convenient travel case with mirror for easy application on the go

Contact us today to learn more about BEYOND™ products and distribution opportunities in your area!
Esthetic dentistry has been an absolute boom over the last 30 years, especially when it comes to such innovative techniques as teeth whitening and minimally-invasive veneers like Cristal Veneers by Aurum Ceramics. Now that the teeth look good, what about the peri-oral and maxillofacial areas around the mouth and on the face? If the teeth look good but we ignore the rest of the face, then we have severely limited what we have done in esthetic dentistry.

It is time to give serious consideration to extending the oral-systemic connection to the esthetic realms and facial pain areas of the face, which dentists are more familiar than any other health-care practitioner. As dentists, we can all do a magnificent job of making teeth look great and also give people a healthy and beautiful smile.

How does Botox work?

Botox is a trade name for botulinum toxin, which comes in the form of a purified protein. The mechanism of action for Botox is really quite simple. Botox is injected into the facial muscles, but really doesn’t affect the muscle at all. Botulinum toxin affects and blocks the transmitters between the motor nerves that innervate the muscle. There is no loss of sensory feeling in the muscles. Once the motor nerve endings are interrupted, the muscle cannot contract. When that muscle does not contract, the dynamic motion that causes wrinkles in the skin will stop.

The skin then starts to smooth out, and in approximately three to 10 days after treatment, the skin above those muscles becomes nice and smooth. The effects of Botox last for approximately three to four months, at which time the patient needs retreatment.
What is dry mouth?

We can all suffer from dry mouth at some point, for example, if we are nervous or stressed. So most of us are familiar with the feeling of not having enough saliva in our mouth to keep it moist and lubricated. For some people, however, dry mouth can be a regular problem. As we get older we are more likely to experience dry mouth, but it’s also a problem that can affect people from their 30s onwards.

What causes dry mouth?

Dry mouth occurs when the salivary glands stop working effectively. Medicines are known to cause over 60% of dry mouth cases, with more than 400 different medications linked to dry mouth. The number of medicines a patient takes is also directly related to the likelihood of experiencing dry mouth. Health conditions are also linked to dry mouth, such as diabetes or Sjögren’s syndrome. People who smoke, who are pregnant, stressed, anxious or dehydrated are also more likely to have dry mouth.

What are the symptoms?

The symptoms of dry mouth can include:
• difficulty in eating, especially with dry foods, such as cereals or crackers
• difficulty in swallowing and speaking
• a burning sensation in the mouth
• taste disturbances
• painful tongue
• dry, cracked, painful lips
• bad breath
• persistent difficulty in wearing dentures
• feeling thirsty, especially at night
• dry, rough tongue. Sometimes the amount of saliva a person produces may be reduced by up to 50% before these symptoms are noticed. These symptoms can sometimes have a profound effect on self-confidence.

Does dry mouth cause other problems?

Saliva plays a very important protective role in the body. It not only keeps our mouth moist, it also helps to protect our teeth from decay, helps to prevent infections and helps to heal sores in the mouth.

Are your patients dry mouth sufferers?

Do they have difficulty swallowing certain foods? Do they feel dry when eating a meal? Do they need to sip liquids to help them swallow dry foods? Are they taking multiple medicines? If a patient answered yes to any of these, he/she may have dry mouth.

Products to ease dry mouth

The Biotène system is specifically designed to treat dry mouth. The different products in the Biotène system allow you to choose the ones that best meet your lifestyle and dry mouth needs:
• 1 product specifically designed to help relieve your dry mouth: the gel provides long lasting relief
• 2 products to help maintain healthy teeth and prevent tooth decay in people with dry mouth: a toothpaste, with fluoride, and mouthwash which can be used twice a day in place of the usual products. These are designed to be gentle on your mouth as they are alcohol-free and don’t contain harsh detergents. Biotène supplements the make-up of normal saliva to replenish dry mouths. It has a patented enzyme formulation that:
  • helps supplement saliva’s natural defences
  • helps maintain the oral environment to provide protection against dry mouth
  • helps supplement saliva’s natural antibacterial system - weakened in a dry mouth. Biotène’s gentle formulation is also free from alcohol and harsh detergents.

What else can a patient do to manage dry mouth?

• Sip water or sugar-free drinks often
• Avoid drinks which dry out the mouth, such as caffeine-containing drinks (coffee, tea, some fizzy drinks) and alcohol
• Chew sugar-free gums or sweets to stimulate saliva flow
• Avoid tobacco as this has a drying effect
• Use a humidifier at night to keep the air full of moisture. To help keep healthy teeth and avoid tooth decay: Brush teeth with a soft toothbrush after meals and at bedtime

Visit www.biotene.com to learn more about dry mouth.
The patient's history may include though patient history and awareness frequently misdiagnosed. Because the primary dental cause is usually seek treatment from a physician or origin have been well documented cutaneous scarring. Root canal space—resulting in minimal correct diagnosis will lead to a simple, can provide reliable information cal region of the area suspected can digital finger pad pressure on the apico-fistulae are sometimes treated of the cutaneous fistula and excision neous fistulae are sometimes treated destructive invasive treat- sinus tract usually leads to diagnosis of an extra-oral sinus tract. It is not uncommon, particularly in young patients, to find a cutaneous fistula at the level of the mental sym- physis, if lower incisors are involved, or in the sub-mandibular region, if a lower first molar is involved. Also, it may be found in the floor of the nasal fossa, if a central incisor is involved.

Correct diagnosis is the key to treating this kind of lesion. A gentle digital finger pad pressure on the apical region of the area suspected can create a discharge of pus. A DentAs can can provide reliable information that will help with the final diagnosis and the subsequent treatment plan. A correct diagnosis will lead to a simple, yet effective treatment—the removal of the infected pulp canal tissue from the root canal space—resulting in minimal cutaneous scarring.

Cutaneous sinus tracts of dental origin have been well document- ed in the medical literature, dental literature, and dermatological literature. However, these lesions continue to be a diagnostic dilemma. Patients suffering from cutaneous fistulae usually seek treatment from a physician or plastic surgeon instead of a dentist. Tab and often undergo multiple surgical excisions, multiple biopsies and antibiotic regimens with eventual recurrence of the cutaneous sinus tract because the primary dental cause is frequently misdiagnosed.

The evaluation of a cutaneous sinus tract must begin with a thorough patient history and awareness that any cutaneous lesion of the face and neck could be of dental origin. The patient’s history may include complaints of dental problems. However, patients may have any history of an acute or painful onset. There may also be complaints of episodic bleeding or drainage from the cutaneous site with persist- ence of the cutaneous lesion. Occa-

sionally, there is a history of injury to the tooth. Correct diagnosis of the cutaneous sinus of dental origin should be suspected by the gross appearance of the lesion. Three cases typically present as erythematous, symmetri- cal, smooth, non-tender nodules of one to 20 mm in diameter with crusting and periodic drainage in some cases. The most characteristic feature of the nodule is its depression or re- traction, bounded by an gutter-surf. This cutaneous retraction or dimpling is caused by the fixation of the tract to the underlying tissues and may be secondary to the healing process or a late finding in active disease. Lesions that previously underwent biopsy and treatment are usually characterised by the absence of at least part of the nodule and frequently by an orifice of draining sinus at the base of the fixed depression.

Endodontic infection, the produc- t of cellular degeneration-bacter- iological processes—and, occasionally, the bacteria themselves within the canal spread through the apical foramen into the surrounding tissue. Thus, a slow inflammatory process begins in the tissue contained within the peri- odontal ligament. Left to itself, it may manifest in a variety of ways, ranging from simple widening or thickening of the ligament to granuloma or cyst. Sometimes a fistula may develop, with the patient reporting intermittent dis- charge of pus.

Fig. 2 The fistula may be found on the muco- os surface of a tooth that is surrounded by a thin wall of soft tissue. The diagnosis of a cutaneous fistula and excision of its entire tract with all the ramifications cannot be considered to comply with the present standard of care. However, Grossman states that such tracts are lined by granulation tissue. In his study, Grossman was unable to identify any epithelium at all. Bender and Seltzer also conducted histological studies of numerous fistulous tracts without finding an epithelium lining. Given the current state of knowledge and scientific data, there is no reason to recommend surgical removal of such tracts, just as there is no reason to be- lieve that even epithelium-lined fistula tracts should not be left after appropri- ate endodontic therapy. Attempts to treat cutaneous fis- tulae with a circular incision of the orifice of the cutaneous fistula and excision of its entire tract with all the ramifications cannot be considered to comply with the present standard of care and should be regarded as highly undesirable. Most of the time, root canal therapy is the ideal treatment for such lesions. However, Gross- man states that such tracts are lined by granulation tissue. In his study, Grossman was unable to identify any epithelium at all. Bender and Seltzer also conducted histological studies of numerous fistulous tracts without finding an epithelium lining. Given the current state of knowledge and scientific data, there is no reason to recommend surgical removal of such tracts, just as there is no reason to be- lieve that even epithelium-lined fistula tracts should not be left after appropri- ate endodontic therapy.

Careful review of the axial slides in the area of tooth 47 (Fig. 2a) offers an idea about the amount of bone destruction in the lower lingual area. The axial slide un- der tooth 46 reveals the commu- nication between the lesion under the mesial root and the mandibular nerve tract (Fig. 4).

Next, we established a clear diagnosis that the lesion was an extra-oral cutaneous fistula of dental origin. The patient was referred to me under double antibiotic therapy (Metronidazole 500mg twice dai- ly, Metronidazole 1000mg twice daily). The patient presented to my clinic the following day, where we started with a detailed questionnaire to collect all the information about the history of the wound. The patient reported that he had been suffering from this fistula for some time already with intermittent phases of discharge of an exudate and numbness of the lower lip. No dental pain was reported. A panoramic X-ray showed some bone rarefaction under teeth 47 and 46, but noiation of the mandibular nerve tract was evident (Fig. 2a). A dental scan with 0.5 mm increment was performed in order to gain a bet- ter idea of the clinical situation. One of the sagittal slides (017) clearly shows the lesion around the distal root of tooth 47, sur- rounding the apical part and de-stroying the cortical bone invading the lower soft tissue (Fig. 2b). Furthermore, the mesial root of tooth 46 showed apical radiculod- ence, invading the tract of the lower mandibular nerve (014; Fig. 5). This pathology explains the numbness of the lower lip, while the pathology around the distal root of tooth 47 explains the extra-oral fistula.

Obviously, these fistulae must be distinguished from congenital fistulae of the neck, both laterally arising from the second branchial cleft-and medial-ly from the facial bone invad- ing the facial bone invad- ing the lower soft tissue (Fig. 2b). Furthermore, the mesial root of tooth 46 showed apical radiocu- loidening, invading the tract of the lower mandibular nerve (014; Fig. 5). This pathology explains the numbness of the lower lip, while the pathology around the distal root of tooth 47 explains the extra-oral fistula.
An intermittent pastie was injected inside the shaped root canal system. The paste of two different antibiotics (Augmentin and Metronidazole) was manually mixed and injected with a paste filler. A hermetic temporary filling was placed for a week. The wound was covered with a dressing of steroids and antibiotic paste to prevent further external infection. A week later, the patient was already showing good progress. The wound had started to close and less inflammation and swelling were observed (Fig. 5). The root canal was reopened and cleaned, and no internal fluids were coming from the periapical region. RealSeal material was used as obturation material in a vertical condensation using RCPSL (Hu-Friedy) and an immediate build-up was performed. Thereafter, the patient was invited for regular control check-ups. A few weeks later, a post-op X-ray (Fig. 6) and photos were taken. The wound seemed to be in good condition and some skin and fibrous tissues were forming.

While I was writing this article, the patient visited Beirut and decided to come in for a check-up. He complained of a muscle disturbance of his lower lip, but all the previous numbness had disappeared. He agreed to perform an i-Cat scan in order to find out what was going on and to detect any pathology. I was amazed by the bone formation and complete healing (Figs. 7–9). The wound had also healed very well (Figs. 10a & b). I contacted a plastic surgeon and asked his opinion regarding the muscle disturbance. He posited that such disturbance of his lower lip, but certainly can be more profitable—is more complicated—and that certainly the challenge in these kinds of cases is to assemble all the pieces of the puzzle and build up a full idea of the clinical situation. Assembling the pieces means that all the diagnostic materials, such as a history questionnaire, X-rays, CT scans, and sometimes biopsy and bacteria culturing, must be provided in order to establish a correct diagnosis. Most of the time, the solution will only be a simple routine that must be performed in certain conditions. Turning to solutions that are more complicated—and that certainly can be more profitable—is not always the right choice, nor is the most ethical one.

The author would like to thank Julia Vordyeva, PhD, interpreter and translator, for her help with this article.

**Discussion**

An important diagnostic modality is the determination of the nature of fluid draining (if any) from the cutaneous sinus. During palpation, an attempt should be made to milk the sinus tract. Any discharge obtained should be scrutinised to determine its nature (saliva, pus or erythroid fluid). Culture and sensitivity testing of the fluid should also be performed to rule out fungal and syphilitic infections.

Laskin elaborates on the physiological and anatomical factors that influence the spread and ultimate localisation of dental infections. Stoll and Solomon also emphasise that the ultimate path of the sinus (irrespective of the source) depends on several factors: most importantly, the anatomy of the tooth involved, muscular attachments to the jaw, fascial planes of the neck, and involvement of permanent or deciduous teeth. Cutaneous rather than intra-oral lesions are likely to occur if the spiers of the teeth are superior to the maxillary muscle attachments or inferior to the mandibular muscle attachments.
MIDDLE EAST EVENTS 2010

MAY
May 4, 2010 - May 6, 2010 - Doha, Qatar
Qmedic 2010
Venue: Doha Exhibition Center, Doha.
Contact Person: Habib Alphonse
E-mail: halphonse@recexpo.com
Venue: Riyadh International Exhibition Center
May 9, 2010 - May 12, 2010 - Riyadh, Saudi Arabia
Riyadh Exhibitions Co.
Tel: +966 1 2295604
Fax: +966 1 2295612
E-mail: slda@sltnet.lk
Website: www.slda.lk
Congress and Exhibition Venue: Bandaranaike Memorial Convention & Exhibition Centre

June 13, 2010 - Jun 16, 2010 - Tehran, Iran
Iranian International Exhibitions Company (IIEC)
Tel: +98 21 88206720-1 // 22662801-4
Fax: +98 21 88206720-1
E-mail: info@iranfair.com
Web: www.iranfair.com // www.iranmedonline.com
Venue: FAIRGROUND - AIRPORT ROAD - DAMASCUS - SYRIA

OCTOBER
Oct 29, 2010 - Oct 31, 2010 - Mumbai, India
IDEM India 2010
KoelnMesse YA Tradefair Pvt. Ltd.
Contact Person: Mr. Krunal Goda
E-mail: k.goda@koelnmesse-india.com
Tel: +91 22 42207803
Fax +91 22 2368 5613
E-mail: info@wds.org.in
Website: www.wds.org.in
Venue: MMRDA Ground, Bandra Kurla Complex, Bandra (East) Mumbai, Maharashtra, India

NOVEMBER
Nov 2, 2010 - Nov 6, 2010 - Alexandria - Egypt
AIDC 2010 - 17th Alexandria International Dental Congress
Faculty of Dentistry, Alexandria University
Tel: +203 481 1787
Fax: +203 486 8286
E-mail: info@aidc-egypt.org
E-mail: a-kahky@hotmail.com
Website: www.aidc-egypt.org
Venue: Hilton Alexandria Green Plaza Hotel

EMS-SWISSQUALITY.COM

SUBGINGIVAL WITHOUT LIMITS
THE DEEPEST PERIODONTAL POCKETS NOW WITHIN REACH WITH THE ORIGINAL AIR-FLOW METHOD

AIR-FLOW MASTER®
is the name of the world’s first
double prophylaxis unit.
With two application systems in
one. For sub- and supragingival
use with matching handpiece and
powder chamber.
Incredibly easy to operate.
Uniquely simple to use.

AIR-FLOW KILLS BIOFILM

The inventor of the Original Air-Flow Method is now first to
cross the boundaries of conventional prophylaxis.

For more information > welcome@ems-ch.com
DENTAL TRIBUNE Middle East & Africa Edition

Trends & Applications 9

When is Botox used?

The areas that Botox is commonly used for smoothing of facial wrinkles are the forehead between the eyes (glabellar region), and around the corners of the eyes (crow's feet) (Figs. 1, 2) and around the lips.

Botox has important clinical uses as an adjunct in TMJ and bruxism cases, and for patients with chronic TMJ and facial pain.

Botox is also used to complement esthetic dentistry cases; as a minimally-invasive alternative to surgically treating high lip line cases; for denture patients who have trouble adjusting to new dentures; for lip augmentation; and has uses in orthodontic and periodontic cases where facial muscle retraining is necessary.

No other health-care provider has the capability to help patients in so many areas as do dentists with Botox and dermal fillers.

What about dermal fillers?

Dermal fillers, such as hyaluronic acid (Juvederm Ultra and Restylane) are commonly used to add volume to the face in the nasolabial folds, oral commissures, lips and marionette lines (Figs. 3, 4).

As we age, collagen is lost in these facial areas and these lines start to deepen. These dermal fillers are injected right under the skin to plump up these areas so that these lines are much less noticeable.

Dermal fillers are also used for lip augmentation and are used by dentists for high lip line cases, uneven lips and to make the peri-oral area more esthetic. The face looks more youthful and is the perfect complement to any esthetic dentistry case that you do.

What’s a dentist got to do with it?

We as dentists give injections all the time; this is just learning how to give another kind of injection that is outside the mouth, but in the same area of the face that we inject all the time.

Dentists also have a distinct advantage over dermatologists, plastic surgeons, medical estheticians and nurses who commonly provide these procedures in that we can deliver profound anesthesia in these areas before accomplishing these filler procedures.

Patients who undergo such treatment by other health practitioners can be quite uncomfortable during the procedure, and indeed this is one of the biggest patient complaints about dermal fillers.

Many dentists are surprised to find that more than half of the United States allow dentists to provide Botox and dermal fillers to patients. Why wouldn’t you provide these services if you already offer whitening and esthetic dentistry to your patients?

I would make the strong argument that dentists are the true specialists of the face, much more so than most other health-care professionals, including dermatologists and plastic surgeons.

It is time to stand up for what we know and what we can accomplish.

Do patients want this?

Is there a market for these services? In 2008, close to $5 billion was spent on botulinum toxin and dermal filler therapy in the U.S.

Think about this: that was money spent on non-surgical, elective, esthetic procedures that could have been spent on esthetic dentistry, but the patient made a distinct choice.

Interestingly, these procedures become more popular in an uncertain economy because patients want to do something to look better that is more affordable than surgical esthetic options.

How do you get there?

Like anything else you do, offering this type of service requires training. The learning curve is short because you already know how to give comfortable injections. I often give training sessions in Botox and dermal fillers and dentists are amazed how easy these procedures are to learn and accomplish compared to everything else we do.

Finding practice models is easy: start asking family and friends who will fight to have you practice on them. If you want even more proof, ask women in your practice if they have had or would like Botox or dermal filler therapy.

You will be overwhelmed at the positive response and shocked at the number of people you know already receiving these treatments.

Conclusion

What’s the next big thing in dentistry? It may come as we start expanding outside of the teeth and gums into the peri-oral and maxillofacial tissues, which is within every dentist’s skill set.
“Zirconia - The Truth”
Open Discussion Forum

4th CAD/CAM & Computerized Dentistry International Conference

13-14 May 2010, Dubai UAE
The Address Hotel Dubai Marina

20 % Discount for the Readers

Dr. Andreas Kuhad, Germany
CAG - Computer Aided Esthetics

Dr. Asar Shaker, Egypt
Understanding Machinable Blocks

Dr. Ralph Ripper, Germany
The Digital Therapeutic Chain - From the Patient to the Production

Dr. Josef Hinterseer, Germany
Proper Cementation to Proper Objectives

Dr. Benoit Philippe, France
Understanding Machinable Blocks

Dr. Raffi Khanjian, Lebanon
The Tooth Preparation for CAD CAM Technology

CME 14 Hours

Platinum Sponsor
Gold Sponsors
Official Sponsors

Conference Bags Sponsor
Other Industry Players

FDI Annual World Dental Congress
2-5 September 2010
Salvador da Bahia, Brazil

congress@fdiworlddental.org
www.fdiworlddental.org

World Dental Show
29 - 31 October 2010, Mumbai

More than 30000 dental professionals expected in 2010

Be in the Forefront of Dental Exhibition in India

• 10 Highly specialized courses
• Largest Exhibition in Asia in 2009
• Scientific Conference in association with University of California, San Francisco

SINO-DENTAL 2010
June 9-12, 2010
China National Convention Centre, Beijing
(Beside Bird Nest & Water Cube)

Joint Organizers
International Health Exchange and Cooperation Centre, Ministry of Health, P. R. China
Chinese Stomatology Association
Beijing University School of Stomatology
www.sino-dent.com.cn
Time to talk about dry mouth?

Dry mouth is an increasingly common condition, primarily related to disease and medication use. In fact more than 400 medicines can cause dry mouth and the prevalence is directly related to the total number of drugs taken.2

Ask your patient
Some patients develop advanced coping strategies for dealing with dry mouth, unaware that there are products available that can help to alleviate the symptoms, like the biotène system.

Diagnosis may also be complicated by the fact physical symptoms of dry mouth may not occur until salivary flow has been reduced by 50%.3

Diagnosing dry mouth
Four key questions have been validated to help determine the subjective evaluation of a patient’s dry mouth:4

1. Do you have any difficulty swallowing?
2. Does your mouth feel dry when eating a meal?
3. Do you sip liquids to aid in swallowing dry food?
4. Does the amount of saliva in your mouth seem to be too little, too much or do you not notice?

Clinical evaluations can also help to pick up on the condition, in particular:

- use of the mirror ‘stick’ test - place the mirror against the buccal mucosa and tongue. If it adheres to the tissues, then salivary secretion may be reduced
- checking for saliva pooling - is there saliva pooling in the floor of the mouth? If no, salivary rates may be abnormal
- determining changes in caries rates and presentation, looking for unusual sites, e.g. incisal, cuspal and cervical caries.

Consequences of unmanaged dry mouth include caries, halitosis and oral infections.

Saliva’s natural defences
Saliva’s natural defences contain a mixture of proteins and enzymes, each of which plays a specific role.1

Protein:
- lactoferrin – chelates iron. Deprives bacteria of iron, which is essential for bacterial growth.

Enzymes:
- lysozyme – disrupts cell walls of bacteria, resulting in cell death
- lactoperoxidase – synthesis of hypothiocyanite, a potent antimicrobial agent.

The biotène patented salivary LP3 enzyme system
The biotène formulation supplements natural saliva, providing some of the missing salivary enzymes and proteins in patients with xerostomia and hyposalivation to replenish dry mouths.

The biotène system allows patients to choose the right product to fit in with their lifestyles:
- relief products - Oral Balance gel.
- hygiene products - toothpaste and mouthwash.

The range is specifically formulated for the sensitive mucosa of the dry mouth patient:
- alcohol free
- mild flavour.

The biotène formulation:
- helps maintain the oral environment and provide protection against dry mouth
- helps supplement saliva’s natural defences
- helps supplement saliva’s natural antibacterial system - weakened in a dry mouth.

GSK welcomes biotène to its oral care family

Everyone has a shade.
And it’s simple to match it.

She’s an A1B. And, with the improved, lifelike esthetics and “single-shade simplicity” of Filtek™ Z350 XT Universal Restorative, it’s the only shade you’ll need to restore her beautiful smile.

Simple to use
- Exceptional handling
- More Body shades for single-shade restorations
- Bold, easy-to-read, color-coded labels

Lifelike esthetics
- Excellent polish
- Wide range of shades and opacities
- Improved fluorescence

Unique nanofiller technology
- Better polish retention than a microfill
- Wears better than leading competitors*
- Outstanding strength for anterior and posterior use

Your simple solution for lifelike restorations is Filtek Z350 XT Universal Restorative.