Planmeca extends university network with €70 million agreement

By Dental Tribune International

HESINKI & KUOPIO, Finland/Riyadh, Saudi Arabia: Dental equipment manufacturer Planmeca has struck a major deal with two dental institutes in Finland and the Middle East. In an announcement released on Friday, the company stated that it had signed an agreement on the delivery and installation of dental equipment estimated to be worth at least €70 million with the King Saud University’s College of Dentistry in Riyadh in Saudi Arabia. Hundreds of dental units and imaging systems will also be provided to the University of Eastern Finland in Kuopio, according to a second agreement.

The contracts mark further substantial business transactions for Planmeca, which reported €70 million in revenue last year. The equipment will be shipped and installed at both dental schools over the next two months, where they will be available for use in the upcoming academic year, the Finnish company said.

>> See FILLING, page 3

MegaGen launches new product in the Middle East

By Dental Tribune Middle East & Africa

Dubai, UAE: MegaGen, a South Korean based company, is one of the fastest growing dental implant companies in the global market. With a focus on finding minimally invasive solutions for clinicians & patients, MegaGen is already known around the world for its Rescue Short & Super Wide system - offering impressive clinical results and proven long term success. The newer AnyRidge system offers a uniquely effective solution to clinicians in compromised or weak bone situations, with unsurpassed initial stability. With the introduction of the new AnyOne system and the Xpeed surface treatment to MegaGen’s impressive range of products, MegaGen offers a solution for every clinical case.

MegaGen has been present in most of the world’s leading implant markets for several years. The AnyRidge international study group has been running in Europe, the United States & Asia since 2009 and we are happy to announce also in the Middle East since earlier this year. On the 12th of September, MegaGen hosted introductory seminars for all clinicians who were able to attend at such short notice. An introduction to the company was followed by a clinical overview of the features & benefits of the systems with crucial insight into the importance of implant systems in achieving initial stability. Techniques for ridge split & shorter implant placement were discussed. MegaGen is planning many international clinical studies including UAE & other Middle Eastern clinicians and is organizing courses & lectures to help understand the advanced product concepts.

Dr Aisha Sultan elected as Vice-President of the APDF

By Emirates Dental Society

Dr Aisha Sultan Alsuwaidi, President of the Dental Society of the Emirates Medical Association (EMMA) rocked the recent Asia Pacific Dental Federation Executive Council Election held in Taipei, Taiwan last June 2012 winning the Vice-President post for the Middle East Region. The contest was fiercely battled by candidates from all over the Asia Pacific region, but Dr. Aisha emerged victorious and secured one of the five Vice-Presidential positions that were at stake.

The election results reflect the admiration and respect that Dr Aisha enjoys within the APDF as a representative of the Emirates Dental Society.

>> See FILLING, page 3
Dental Tribune Middle East & Africa Edition kick off!

By Dental Tribune International

LAGOS, Nigeria: Last month, the Lagos State Government revealed that it is planning to congregate about 300,000 students from different local schools in order to beat the Guinness World Record for the most people brushing their teeth simultaneously.

The event will be organised in the scope of a new dental care program in Lagos. In order to promote better oral hygiene among Lagosians and adolescents in particular, the new preventive dental care program will be implemented in the city’s primary health care centres from October.

“It is a school-based oral health intervention programme that will culminate in a world record attempt for the number of people brushing their teeth simultaneously at multiple locations,” announced Dr Ye-wande Adesina, Special Adviser to the Governor of Public Health, during a world press conference last month.

At noon on 5 December this year, the government hopes to assemble students from about 300 local schools in Lagos, identified through the Ministry of Education, to brush their teeth for one minute, said Dr Bakare Lawal, the project’s head.

In addition, Adesina stressed that the project is aimed not only at breaking the world record, but also at providing vital health information. “The world record toothbrushing challenge is an opportunity for oral health to be brought to the forefront for Lagos State and Nigeria,” said Dr Lola Aghaje, chair of the state chapter of the Nigerian Dental Association.

The current record is 177,003 people brushing their teeth simultaneously at 380 locations across India in an attempt organised by Colgate-Palmolive in association with the Indian Dental Association on 9 October 2007.

By Dental Tribune Middle East & Africa Edition

Mediclin International Acquires Remaining Shares of Emirates Healthcare Holdings Limited

By Dental Tribune Middle East & Africa Edition

The Varkey group, owner of GEMS Education, has commented on this decision to sell as being in line with their goals to refocus more of their attention towards education. In a recent press release, Varkey Group senior director C.N. Radhakrishnan affirms this as their goal. “The decision by Varkey Group to exit its healthcare interest is only due to the Group’s strategic intent of continuing to focus and grow its education business at a faster pace globally,” Varkey Group holds Mediclin and the management and staff of Emirates Healthcare continued success in the region.

In an earlier statement, Mediclin International CEO Danie Meintjes was quoted as saying, “This transaction is the logical next step as we continue to invest in attractive growth and development opportunities across our operations in Southern Africa, Switzerland and the United Arab Emirates. Emirates Healthcare has grown at exceptional rates since Mediclin’s entry in 2006 and the opening of The City Hospital in 2008, Dubai’s largest private hospital. Based in Dubai, Emirates Healthcare is ideally positioned to benefit from the ongoing growth within the United Arab Emirates and surrounding regions.”

Following the stated goal of continuing to invest in attractive growth and development opportunities”, Mediclin, also operating the largest private hospital chain in Switzerland, stated earlier this month that they would raise 5 billion rand through a rights issue to refinance debt and expansion, and was also stated to be in advanced talks with Standard Chartered Bank regarding a debt funding and is currently selling its newly acquired stock to existing shareholders, with some of the rights offer proceeds to pay for expansion abroad.

By Dental Tribune Middle East & Africa Edition

The Emirates Dental Society Board visits Taiwan

By Dental Tribune Middle East & Africa Edition

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Dental Tribune Middle East & Africa Edition | November 2012

Minimizing risks using conventional and digital shade determination, shade communication and shade control

(3-part series)

The technological revolution from conventional to digital technology is gathering increasing momentum in a number of industries. At the same time, customer expectations are also growing, both in terms of greater individuality and quality, and also with regard to faster processes at a lower price.

As these expectations apply to many areas of our lives, it is natural to expect that a guide should also be available for the area of cosmetic dentistry that guarantees individual, aesthetic and superior quality tooth shade reproduction.

The keystones to prosthetic success

Shade determination, shade communication, shade reproduction and shade control are the four keystones of an efficient, standardized process chain in the fabrication of high-quality dental restorations. This structured and standardized approach guarantees the best possible treatment of the patient’s needs by the dental surgeon and dental technician. Shade determination is the basis here for all subsequent steps, and so must be performed thoroughly and accurately.

The issue of tooth shade is one of considerable importance to the patient. This is due to the fact that for patients, shade is one of the very few tangible points of reference that they have when it comes to evaluating restorative treatment.

VITA: setting shade standards for 50 years

Those involved in shade taking have a variety of determination systems at their disposal for unique shade description. It has been over 50 years since VITA Zahnfabrik introduced the VITAPAN classical shade guide. This original A1-D4 shade guide is considered the standard internationally in tooth shade determination and classifies tooth shades as A1-A4 (reddish – brownish), B1-B4 (reddish – yellowish), C1-C4 (grayish shades) and D2-D4 (reddish – gray).

In a further step towards individual determination of the tooth shade, VITA developed the SYSTEM 3D-MASTER, which was the first tool to illustrate the tooth color space in a structured and comprehensive fashion. This approach is based on the fact that naturally-occurring tooth shades can be determined in a systematic fashion by selecting tooth lightness, chroma and hue. Naturally-occurring tooth shades vary most strongly in terms of degrees of lightness and as a result, incorrect determination is most clearly visible here. The 3D-MASTER SYSTEM uses this information and classifies the 29 sample teeth into 5 levels of lightness, 3 levels of chroma and 2 hues. With the VITA Linearguide 3D-Master, this approach has been perfected – the person taking the shade can determine the tooth shade precisely and methodically in just two steps (1. Lightness, 2. Chroma and hue).

Digital dental shade taking – fast and precise

Fast and objective results for tooth shade measurement are prerequisite for an effi...
cient digital workflow. VITA developed a digital shade-taking device because, in conventional shade determination, external influences and the individual perception of color of the person taking the shade can have a significant impact on the process chain, right from the start of the reproduction process.

The digital shade-taking device VITA Easyshade was launched in 2004, and has been continually improved since then. Now in its third generation, today’s VITA Easyshade Advance allows the user to determine tooth shades objectively in a matter of seconds. The high measuring accuracy is based on spectrophotometric technology, which ensures that tooth shades can be determined regardless of ambient lighting or reflection. The measurement results are specified in VITA classical A1–D4, VITA SYSTEM 3D-MASTER and in VITABLOCS shades. It can be used to measure and verify both natural dentition and ceramic restorations, allowing the user to implement their own quality management process.

An additional tool is the VITA ShadeAssist communication software that can be combined with VITA Easyshade Advance to optimize the process chain. In the coming issues, we will be reporting on the areas of “Conventional and digital shade communication” and “Shade reproduction and control”.

VITA Zahnfabrik H. Rauter GmbH & Co. KG
Headquartered in Bad Säckingen/Germany, VITA Zahnfabrik H. Rauter GmbH & Co. KG has been developing, producing and marketing innovative solutions for dental prosthetics according to consistently high quality standards for over 85 years, and has been known from the very beginning as a pioneer and worldwide trendsetter. The VITA shade standard, for instance,
Dental occlusion/temporomandibular joint and general body health

Drs Yong-Keun Lee & Hyung-Joo Moon discuss clinical evidence and mechanism of an underestimated relationship

**Correlation between trigger points and acupuncture points**

Although separated by two millennia, the traditions of acupuncture and myofascial pain therapies share fundamental similarities in the treatment of pain disorders. Recent reports have suggested substantial anatomic, clinical and physiological overlap of the myofascial trigger points and acupuncture points, and the analogy between the trigger points and acupuncture points has been discussed since 1977, when 300 per cent anatomic and 71 per cent clinical pain correspondences for the myofascial trigger points and acupuncture points in the treatment of pain disorders were reported. A number of similarities between them were also suggested. The two structures have similar locations and needles are used at each point to treat pain. The pain associated with the local twitch response at trigger points is similar to the de qi sensation, and the referred pain generated by needling trigger points is similar to the propagated sensation along the meridians. It was pointed out, however, that the acupuncture points located at the trigger points are not frequently used by acupuncturists, and do not share the same clinical indications as the trigger point therapy. It was further argued that the claim of 71 per cent correspondence between the acupuncture points and the trigger points is conceptually impossible. Furthermore, even putting this conceptual problem aside, no more than 40 per cent of the acupuncture points correspond to the treatment for pain and, more likely, only approximately 18 to 19 per cent of the points are actually correlated. The correlation between the trigger points and the acupuncture points clearly need to be further investigated in the future.

The fascial connection theory we propose can explain the functional connection between dental occlusion (TMJ) and other parts of the body based on either myofascial release or the qi and meridian system, or a combination of both. Therefore, dental occlusion/temporomandibular joint dysfunction may exist in the acupuncture meridians, which tend to be located along the fascial planes between muscles or between a muscle and bone or tendon, and the connective tissue.

In view of experimental evidence, it has been hypothesised that the network of the meridians can be viewed as a representation of a network of interstitial connective tissue. These findings are supported by ultrasound images showing connective tissue cleavage planes at the acupuncture points in human beings. Rather than viewing acupuncture points as acupuncture meridians, it has been proposed that these points might correspond to sites of convergence in a network of connective tissue permeating the entire body, similar to highway intersections in a network of primary and secondary roads.
Conservative dentistry achieved through a multi-disciplinary approach
Combining orthodontics and CAD/CAM technology to achieve conservatism for a rehabilitation case

By Dr. Thomas Colina, DMD

C omplex treatment needs can necessitate oral rehabilitation of patients. Often these patients will require a multi-disciplinary approach to correct problems. When patients have significant concerns, such as severe malocclusions or destruction of dental tissue, oral rehabilitation can entail extensive treatment that may involve reconstructions.

To return the patient to optimal function, regain normal form and address possible concerns such as esthetics, an integrated approach that involves various disciplines needs to be taken. The challenge posed to a particular treatment plan may involve the treatment of many teeth and possibly the need to prepare a significant number of teeth and corresponding dental tissue.

Another challenge in reconstruction cases is the cost associated with the restoration of numerous teeth. Cost may be a factor for patients. There are often many options and approaches that can lead to the same successful treatment outcome. The variety of options can be at different ends of the spectrum. Diagnostic tools, including tomograms and the use of CAD/CAM systems, are useful in achieving complex treatment goals. This paper presents a treatment option that is an alternative to the reconstruction approach through the innovative application of multiple disciplines and current technology.

Case presentation
A 31-year-old male patient presented with the chief complaint of his upper front teeth restorations breaking off a few months after being placed. He has had the front teeth restored numerous times with the same outcome. A comprehensive examination and records revealed the following findings.

Medical history and functional concerns
There is a history of arthritis in the family. The patient experiences transient pain from his back, neck and shoulders. He has noted he clenches and grinds his teeth day and night. He was involved in a motor vehicle accident and sustained head trauma 12 years before his presentation to our office. Along with routine examination protocols, the temporomandibular joint (TMJ) was examined using a TMJ health questionnaire, range of motion examination, muscle palpation and TMJ imaging.

TMJ findings and symptoms were: normal maximum opening to 33 mm; no limitation in excursion; at opening, there is a 2 mm deviation to the left. There is a posterior slider from centric relation to maximum intercuspation. The patient noted cracking noises from the TMJ at opening and closing, and there has been occasional locking of the TMJ through the years. He has slight hearing loss and tinnitus.

As a routine for patients exhibiting TMJ dysfunction, a TMJ tomogram series was taken. Tomographic series was achieved by use of a CranexTome (Soredex, Tuusula, Finland). The CranexTome has a unique spiral tomography for cross-sectional images. Interpretation of hard tissue imaging study would include the evaluation of condylar and temporal component morphology and integrity of the bony articulating surfaces. The TMJ is assessed for signs of remodeling, degenerative joint disease or morphological variations affecting the TMJ, jaw and skull.

Condylar position in maximum intercuspation is evaluated. The diagnostic tools are used not only for initial assessment to attain a working and definitive diagnosis, but during and after treatment to assess attainment of the treatment objectives. The corrected lateral TMJ view taken at maximum intercuspation reveals a posteriorly displaced condyle and morphological bending of the condyles (Fig. 1). The joint vibration analysis (JVA Bioresearch International, Milwaukee, Wis.) is used to assess TMJ health for patients and yielded fairly normal vibrations of the TMJ.

Skeletal pattern
Based on a cephalometric analysis, the patient presented with a Class I skeletal pattern with a slight retrognathic mandible.

Occlusion
A visual examination and cast analysis revealed a Class II dental pattern with a deep overbite and tight overjet, fractured upper incisor restorations, slight crowding of the upper and lower arches, and severe worn dentition (especially the anterior teeth). The upper incisors were retroclined, and the upper and lower incisors had severe wear (Fig. 2).

There was generalized moderate wear on the posterior teeth. The patient presented with a posterior shift of 2 mm from centric relation to maximum intercuspation.

Treatment options
The following treatment options were presented to the patient:
• Reconstruction of the arches to achieve an ideal occlusion. This first option would entail splint therapy and eventual reconstruction to achieve a stabilized occlusion. This approach will provide a stable occlusion and will entail restoration of numerous teeth — both anterior and posterior — to support the anticipated change in vertical dimension. The disadvantage to the approach is the introduction of artificial material in the mouth and the need for maintenance of the restorations. Of course, this approach also entails significant dental tissue reduction to provide partial and full coverage restorations to support the occlusal scheme.

In addition, although the treatment can be provided in a fairly short amount of time, the cost for the restorations can be significant for most patients.
• Orthodontically to achieve the best possible occlusion and orthopedic alignment. This approach provides for the patient an option to conserve dental structure, minimize the number of restorations to provide a stable and functional occlusion, and allows cost for the treatment to be more manageable. The disadvantage is the time required to achieve orthopedic and orthodontic correction.

Treatment plan details
Straight wire appliance treatment (SWA) was proposed to attain ideal inter- and intra-arch alignment augmented by a mandibular repositioning mechanism by way of posterior build-ups and elastics or a fixed orthotic or use of a Twin Force Appliance. This phase of treatment was anticipated to last 20 months. After the orthodontic treatment, restoration of the six anterior or maxillary teeth with porcelain restorations would follow. The lower incisors will be evaluated for the need of restorations. The need for a lower bruxing appliance would also be evaluated after the completion of the restorations.

Discussion of the treatment
The first phase of the treatment was the provision of orthodontic therapy using GAC Innovation C Self Ligating Bracket System. The Innovation C bracket system has a highly translucent porcelain structure and a rhodium coated clip, which provide superb esthetics as well as a high-torque component for the incisors of 17 degrees for the upper central and 10 degrees for the upper lateral incisors. One of the main goals for the treatment was the correction of the maxillary incisor torque. The retroclined upper incisors had contributed significantly to the severe wear of the anterior teeth and had resulted in an intercuspation that produced a posteriorly displaced condyle. The correction of the incisor torque brought about a natural repositioning of the mandible, which was a treatment goal for the patient. The JVA, which has been proven effective in discriminating joint vibrations to assess TMJ 2 condition, was utilized to evaluate the TMJ during and after treatment.

Anterior repositioning of the mandible has been described in the literature as a viable approach in the treatment of Class II malocclusions and TMJ dysfunction.
Woodside) and McNamara describe a functional approach to the correction of the Class II malocclusion. After anterior repositioning therapy has had a history of more than 50 years. Gelb6 referred to his repositioning appliance in 1969 and described the Gelb 4/7 position, which is currently accepted in the literature and recognized by many practitioners treating TMJ dysfunction to correlate with the physiologic position of the condyle in the fossa (Fig. 3). Severe dysfunction at protrusion and canine guidance at positioning the mandible upon removal of posterior occlusal rests are necessary. Posterior resin build-ups with Class II elastic therapy were sufficient to erupt the posterior teeth to achieve stability of the posterior segment. The condylar position was anterior to protrusion and canine guidance at positioning of the mandible (Fig. 3). Several functional appliance designs and their efficacy of improving TMJ dysfunction through mandibular repositioning have been described in later literature.7 Simmonds further describes the alleviation of symptoms after mandibular repositioning as noted, there was a natural anterior repositioning of the mandible upon removal of the centric interference in this patient, and appliance therapy was unnecessary. Posterior resin build-ups with Class II elastic therapy were sufficient to erupt the posterior teeth to achieve stability of the posterior segment. The condylar position was anterior to protrusion and canine guidance at positioning of the mandible (Fig. 3). Several functional appliance designs and their efficacy of improving TMJ dysfunction through mandibular repositioning have been described in later literature.7 Simmonds further describes the alleviation of symptoms after mandibular repositioning therapy. Gelb5 referred to his reposi- tioning appliance for the anterior teeth. Upon evaluation of the post-orthodontic occlusion, to provide an occlusion with anterior guidance and delivery of restorations. The system uses a laser capture to acquire a digital impressively bonded.11 The pressable lithium di- silicate is indicated for inlays, onlays, thin veneers, veneers, partial crowns, three-unit anterior bridges, three-unit premolar bridges, telescope primary crowns and implant restoration while the machinable lithium disilicate is indicated for all the previous applications except bridges.12–14

Summary
Reconstructive treatment usually entails significant correction of malocclusion and the maxillomandibular relationship. Many patients requiring reconstruction commonly present with varying functional concerns, including TMJ dysfunction and associated symptoms. Technology, such as tomography and the use of IVA, can serve as standard equipment in the diagnosis and treatment of these patients as well as aid in objectively evaluating the TMJ condition during and after the treatment. The goal of any treatment is to provide the patient with good esthetics, comfort and long-term function. The innovative melding of disciplines and the use of current materials and technology can allow conservation of dental tissue that is irreversibly altered and removed using the traditional reconstructive approaches.

References

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MEDIA CME Self-Instruction Program
Dental Tribune Middle East & Africa in collaboration with CAPP introduce to the market the new project mCME - Self Instruction Program. mCME gives you the opportunity to have a quick and easy way to meet your continuing education needs. mCME offers you the flexibility to work at your own pace through the material from any location at any time. The content is international, drawn from the upper echelon of dental medicine, but also presents a regional outlook in terms of perspective and subject matter. How can professionals enroll?

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Introducing the Dental Lab Tribune

By Rodney Abdallah

For the first time dentists and dental technicians will be together in one pool of news, business, industry, politics and science in the world’s leading dental newspaper.

As a Certified Dental Technician, it is my great pleasure to welcome you to the first Dental Lab Tribune edition within Dental Tribune Middle East & Africa.

I am proud to announce the birth of this highly anticipated section which is part of the Dental Tribune International Publishing Group, composed of the leading dental trade publishers around the world. Its combined portfolio includes more than 100 trade publications that reach over 650,000 dentists in more than 90 countries in 25 languages.

It is highly important to recognize the importance of the Dental Laboratory and its Technicians who play a vital part of any Dental Team. It is the place which mixes science with art, the backbone of any Dental Clinic much needed in providing the perfect smile as end result.

Dental Lab Tribune will be entirely dedicated to providing the latest news, state-of-the-art research & developments, products and education with special focus on developing further Dental Laboratories and the already skillful Dental Technicians. Working together with world leading Dental Professionals, Dental Lab Tribune Middle East & Africa will be delivering the much needed information to its readers. As part of the Editorial Board, together with my colleagues we intend to keep Dental Lab Specialists informed of the latest developments, events and advances in both general and specific Dental Lab topics in an easy and accessible format including graphs, tables and figures which will appear in their original articles.

By placing an emphasis on publishing novel and high-quality research papers together with the latest industry developments related to the Dental Lab, the Dental Lab Tribune section aims to influence the practice of Dentistry on a Dental Lab, research, industry and policy-maker level on international basis.

Readers will have direct contact with industrial players in a knowledge exchange environment, creating a forum for discussions, questions and exchange of valuable information through our “feedback sessions”.

For the above targets, I would like to invite all Dental Lab Specialists to interact with Dental Lab Tribune. I look forward to exchanging all related Dental Lab experience with you.

Yours faithfully,

Rodny Z. Abdallah
Certified Dental Technician

Crown VS Veneers

All the way to creating esthetic Reconstruction of aesthetic & its functionality in combined (Crowns-Veneers) case.

Dr. Sami Buseo & CDT, Alham Farah
Damascus/Syria

45 year old female presented to the clinic unsatisfied with the appearance of the composite veneers she had on her upper and lower anterior teeth, besides a phonetic problem with the letter S in particular. She desired functional and aesthetic restorations.

Diagnosis:

Intra Oral clinical exam showed discoloration, lack of vitality, and poor appearance of the composite veneers she had on her upper and lower premolars, plus a little deep bite in the central occlusal jaws relation, what prevented from having proportionate dimensions (width to length). Radiographic testing revealed good and had endo-treatment for different teeth with a questionable over all prognoses. Also it appeared to have generalized horizontal bone resorption, which played a major role in the loss of the inter-dental papilla.

Fig 1

Preliminary Clinical Treatment:

• Extraction of: 17
• Selective endo-treatment for: 14,15,16,26
• Casted post and core for 36,37 (cemented with Vivaglass glass ionomer cement).
• Fiber reinforced composite post and core for 22,26 (posts were cemented using Variolink II and a composite core were built up)

Restorative Treatment Plan & Implementation

Prior to setting up a plan, the dental technician examined the patient’s oral cavity and face carefully at the dentist’s office, answered all her questions and developed an idea about her expectations. A collaborartistic plan by the dentist and technician then was created. Treatment workflow was initiated by taking preliminary impressions.

New Vertical Dimension.

Taking into consideration that our priorities were the reconstruction of aesthetics and its functionality, the dental technician proceeded with a diagnostic wax-up in the new planned vertical dimension of occlusion on the upper teeth and 36-37 from the lower teeth (the missing vertical dimension was gained by means of waxing up to the new occlusion level).

According to the new vertical dimension, a diagnostic template of silicon (silicon index) was made to the upper and lower teeth to be used as a visual aid, as a preparation guide to the dentist, and as a mold for placement of the temporary restorations in the new vertical dimension of occlusion.

Determining restorative materials and corresponding preparation forms

To be restored by All-ceramic crowns from IPS Emax Press, maxillary and 36,37 teeth were prepared with the aid of the silicone index. The prepared finishing lines of the abutments had rounded shoulder. According to esthetic and biological considerations, they were either equigingival or supragingival.

Fig 2

To be restored by All-ceramic veneers from IPS Emax Press, The Six interior lower teeth were prepared with the aid of a silicon index. The prepared finishing lines of the abutments were chamfer and equigingival.

Fig 3

Final impressions were taken to the upper and lower teeth with addition silicone (Virtual silicone from Ivoclar Vivadent) The shade of the final restorations was chosen according the patient desire, her skin color and the shade of the natural (not treated) lower posterior.

Direct temporary restorations were made with the aid of the Index, and no signs or symptoms of discomfort were observed or reported over two weeks.

LAB WORK:

Ingot judgment selection

I chose the new V1 impulse ingot from IPS e.max press, because the final shade chosen A1 was a little extra bright, but before taking the final decision, I had to make sure that the prep color was vital with no discoloration spots on its surface (ND1, ND2) and especially in the lower veneers due to the limited coverage capability, as I learned from my experience that the degree of translucency in Value ingots placed between that of the LT and HT ingots and little more toward the HT.

For interiors, I pressed the V1 as a full anatomical structure and proceeded with a cut back technique simultaneously on the entire upper crowns and lower veneers. For upper posterior, I pressed the V1 as a cusp supported design copings. and proceeded with the layering technique except teeth 24-25, and since both abutments used here are metal posts, I pressed HO1 (high opacity), then proceeded with the layering technique. (Fig 4)

The internal effects concept.

Light absorbing materials are incorporated into the layering scheme to allow light to penetrate into the tooth more rapidly; these materials are usually applied to the incisal third or to the proximal surface of the tooth. Besides their light-absorbing properties, teeth have light-reflecting properties too.

Fig 6: The cemented lower veneers showing how internal effects scheme treat light.
The reflecting materials have to be adequately reflective without being opaque. The light-absorbing materials should not be applied excessively to produce grey and glassy looking results. We don’t want to fabricate teeth that look great on the model but appear grey and glassy in the mouth.

**Foundation bake.**

1st. Shading the cervical third and bring it closer to A1 by using Shades from IPS Emax Ceram.
2nd. Since my goal is to create teeth that demonstrate the entire spectrum of effects shown by natural dental enamel, I used Impulse material on the incisal third to achieve this spectrum. (Fig 5)
3rd. Sprinkling transpa neutral powder on the whole surface, to cover the parts that are not yet covered by powder materials, lowers the value of the V1 frame, and match it accurately to A1 value wise.

**Second bake:**

I used shaded Cervical Transparent powder on the cervical third in the second bake. This material demonstrates slightly higher fluorescence than the convenient transparent material, and gives us a smooth transition to the pink gingiva. (Fig 6, Fig 7) show clearly the internal effects on the upper crowns and lower veneers after cementation, the actual look in the mouth and the way they treat light.

**Back to the clinic with try-in**

The patient had a clinical try-in of the final restoration; notes and desires of the dentist and the patient were taken into consideration. Disharmony was noted in the smile line (misalignment with the eye line) (Fig 8, fig 9, fig 10), an important issue that would have been missed if a clinical try-in was not done. And this is where taking pictures of the patient’s lips and face plays a crucial role in the technician work quality, so he would be able to make the appropriate adjustments while observing these photos.

**Third bake:**

Fixing the smile line was the main adjustment needed, so I added incisal edge, created the Halo effect (which is caused, in natural teeth, due to light refraction at the incisal edge), and is usually duplicated by using certain material (IE powder from IPS Ceram Impulse).

**Posters crowns** were built up using the layering technique with IPS Emax Ceram Dentin, Impulse and Incisal. (Fig 11)

**Surface Texture and glaze:**

Ovoid tooth usually is more convex than any other tooth shape, has a rounded outer shape, and curvilinear transition angles with a few lobes. This is why a very narrow and shallow vertical depressions were created on the labial surface of the centrals and laterals giving the interiors their soft esthetic composition. (Fig 12, fig 13)

**Closing the gingival embrasures:**

As you noticed from the preoperative situation, the unhealthy loss of the grayish interdental papillae is a consequence of wrong countereting in the direct composite, where contact areas were elongated toward the tissue, what made the gingival embrasures too close, impinging on the tissue and creating unhealthy periodontal condition. Therefore the tissue receded; and now for the papilla to grow back, the distance between the contact points and the tips of the papilla must be less than 3 mm, which was the main focus of the contouring on a non separated stone model where papillae are still represented there.

**Cementation and follow up:**

Upper anterior restorations and premolars were finally cemented with variolink-N (Base and catalyst), lower anterior veneers with variolink-N (only Base), and posterior crowns with Vivaglass (glass ionomer) cement. (Fig 15)

During the follow up appointment, a final check up and modifications were made to eliminate all occasional interferences.

**Conclusion:**

Being able to Choose the same ingot for fabricating every single restoration in this case (whether they were full crowns OR veneers) was a big advantage, it serves in achieving the accurate matching and harmony among all the restorations in the following dimensions (Value, Hue, Chroma, translucency, depth...) as long as the thicknesses were close.
Interview: Dr. Rani, Dean of College of Dentistry, University of Sharjah in UAE

"We also have a dental technology program - a diploma of dental technology where we train future dental technicians, who are very heavily involved in using CAD/CAM technology in their studies.

"Here at the University of Sharjah, Dental College, we deliver the knowledge and we take the students through a special experience"

Dr. Rani, you said you were form Malaysia, as I understand you had your formal education there at the Royal Military College. You soon after travelled the world, continuing your studies in such places as Iraq and Scotland, could you tell us a little bit about what influenced your decisions and how your experience was?

Yes. I opted to seek higher training in dentistry and in my dental specialty that is oral and maxillofacial surgery. In the United Kingdom. So following my graduation from the University of Baghdad, in Iraq, in 1983 I did some training, and I was in the armed forces and I went around the world. Then I decided to go for higher studies, so we landed in the UK in 1989 and from there on I was lucky enough to be attached to several teaching hospitals in Scotland and England. I did my surgical fellowship at the Royal College of Surgeons in Glasgow, as well as England and I completed my training as a registrar in oral and maxillofacial surgery. But finally after a good number of years, we decided to return home to Malaysia because, certainly, of opportunities. I was appointed as a dean at the dental school in Malaysia, University Sains Malaysia. I was given the role to build a school, build the infrastructure, develop the human resource, to change a traditional curriculum and was very successfully. And based on that experience I was invited to come to Sharjah, United Arab Emirates to repeat what I had done, with lesser mistakes!

What can you say about what you’ve learned about the dental scene here in the region? What changes you’ve seen, and how you expect it to change from here?

Well, I’m in the Middle East, but certainly while I am in the Middle East, I’m in the UAE. This is a country that’s opened its doors to professionals coming into Dubai, and compete amongst themselves for the betterment of mankind. Therefore in my profession, in dentistry, I found that there’s a good number of dentists that are excellent, who are very competitive, that produce very good work. I’ve met dentists coming from many parts of the world, and I learned about different systems of dentistry and dental training background when I talked to them. So this is a place where dentists form different cultures and different training backgrounds come to meet. And I must say that the standards are very high, so much so again because this country has a very organized health system, regulated by the Ministry of Health, and they have an excellent licensing system, and regulations are in place to regulate these dental practitioners who come from so many countries. So I must say that the dental market here is big, and of very high quality. And therefore when I met colleagues who are practicing in Dubai and Abu Dhabi and even in Sharjah who have patients who are coming in from outside the country, I must say that these patients are actually health tourists coming to get dental treatment in this country. It’s not a surprise because this country has the platform to offer these services, so I must say that we are in a very, very exclusive dental environment amongst excellent dental colleagues.

So how would you say this rising interest in dental education here in the region is affecting the scene? Would you say that a lot of the students are interested in giving back to this community? Or are more willing to impart their learned knowledge around the world? How would you say the education scene has influenced the professional scene?

That’s a very important point. To see how the dental education system or, in fact, how does the curriculum move the students to choose their interests. In the program in the University of Sharjah we develop the content of the program, we deliver the knowledge and we take the students through a special experience, such that at the point of graduation they are prepared to become general practitioners who can provide a basic dental care in general practice with a special emphasis in community service. So we develop in our students, the passion to care for the community.

As we all know in many big cities around the world, dentistry is a highly profitable business, if you want to look at it from a business point of view, and as it’s a very profitable business, the cost of treatment is very high, it may not be for all levels of the community there. It would be for the middle income, higher classes. It would be advantageous if we deliver such philosophy to our students here, because our students come from 64 countries around the world. As we know an expatriate population and our students are children of these expatriates, and we need to prepare them so that they are able to deliver their knowledge and skills to their own community. And they come from countries that have very high GDP, high income countries, and from countries that are still developing. So our curriculum meets the needs of these students, so I must say that we train highly qualified and highly competent general practitioners to deliver their services for the various levels of socio-economic status.

As in any medical related field, the industry of dentistry is always changing. Especially considering a trend that the world is seeing now with the use of advanced technology, we have also introduced the CAD/CAM technologies in our dentistry being pushed farther than it has before in the way that a lot of professionals and clinicians are constantly changing the way they completely perform. How has this affected the curriculum, or the way you teach your students? What are you doing to keep up with these changes?

Well certainly the computer has changed our daily lives: its changed the way we work at our office and the way we live at home, in fact he way we travel to countries; it’s because of computers that we can fly high, we can fly faster and we can be anywhere in the world within a few hours. So computers have affected dentistry very much. But I must say that computer related technology in the medical and dental field is not new. It has been around for the past thirty or forty years, but I must say that in the early years in the introduction of computers to healthcare systems and health-care technology, it has not been very successful because it has been introduced to senior dentists and doctors who were born before the era of computers, so they do not know how to operate computers! But then, if we look at our students today, research has shown that all children who are born after 1980 are very computer literate, and there are many publications about that. So we have taken this into consideration, and we have found that when children are educated in an environment where it is not digital, they don’t find the lesson interesting. So when students learn in a classroom using notepads and chalk and blackboard, method of teaching they find the lesson very boring, because their life is digital, AND they can cope with it.

Therefore we consider all these factors, and because we know that the computer industry will take the dental industry to a different level, and it has happened now and will in the near future, we have added the CAD/CAM technologies in our dentistry, we have also introduced our students to methods of assessing and planning dental implants using software, to analyze where is the best site to place dental implants in the patients jaw, and all this planning is done using software. So coming back to CAD/CAM, we have started delivering lectures to students in CAD/CAM technology, we are the biggest investor in CAD/CAM technology education in this region, where for your information, we have four CAD/CAM systems in our clinics and labs, and all the systems are the Sirona Systems, and our dental technicians are also trained in using these technologies.

We also have a dental technology program - a diploma of dental technology where we train future dental technicians, who are very heavily involved in using CAD/CAM technology in their studies.

"We are in a very, very exclusive dental environment amongst excellent dental colleagues."
Center for Advanced Professional Practices successfully expands to Asia-Pacific Region

By Dental Tribune Middle East & Africa

Center for Advanced Professional Practices (CAPP), known for its 6 CAD/CAM & Computerized Dentistry International Conferences in Dubai and 3 Dental Facial Cosmetic International Conferences at the famous Jumeirah Beach Hotel Dubai, has recently expanded to the Asia-Pacific Region with its first event beginning October 2012.

CAPP Asia - the recently opened branch in Singapore, organized the 1st Asia-Pacific, 7th CAD/CAM & Computerized Dentistry International Conference successfully at the Marina Bay Sands Convention & Exhibition Center in Singapore on 6-7 October 2012. The Conference brought together more than 521 Dental Professionals from 44 countries, all treated to an exciting weekend packed with lectures on the latest developments, continuing the reputation as the industry’s leading unique event entirely focused on the A-Z process of Digital Dentistry. The event was proudly supported by the Singapore Dental Association, the accrediting body of the scientific programme. Figures are based on the event post-show report.

The event was opened by Singapore’s Chief Dental Officer and former president of the Singapore Dental Association, Prof. Patrick S.K. Tseng. The congress included presentations on hybrid dental materials and the aesthetic limitations of CAD/CAM, among other topics. A highlight was the One-visit chairside dentistry Theatre Presentation by internationally acclaimed presenters Dr. Michael Dieter and Joerg Vogt from Germany – a concept started by CAPP 3 years ago in Dubai.

The 1st Asia-Pacific congress also witnessed The Dental technicians’ Parallel Session, introduced at CAPP’s last congress in May 2012 which was included alongside the main programme. The parallel session covered various aspects of using digital dentistry in the lab environment, offering attendees contemporary, technology-focused education.

The event received sponsorships by major market players, including Sirona Dental Systems, Ivoclar Vivadent, AmannGirrbach, Wieland, Easy Shape—Roland, 3M ESPE, Objet, ClearPath and VITA Zahnfabrik, which gave attendees the opportunity to get hands-on with the latest products and treatment solutions in the field.

CAPP has been organizing congresses for dental CAD/CAM and Computerized Dentistry in Dubai since 2006. Its latest event was attended by over 800 dental professionals from 24 countries, according to its figures. The congress in Singapore was the first time that the company held this kind of event outside The United Arab Emirates.

“You have done fantastic work. Great! Congratulations, fantastic organization and high class. To see you in Singapore I could feel like I am at home. Wherever you go with your conference it is always a big success! Thank you for putting all professionals into your conferences.”.

– Bruno Cyglewicz, Dubai.

“It’s a great feeling actually to be here at the CAD/CAM Congress here in Singapore, everyone is excited to learn more about the CAD/CAM market here in the area”.

– Dr. Khaled Abouseada, Saudi Arabia

“Very positive, I really do like this event. I can only hope this event will be following up next year, same time, same place. think your reputation is following you”.

– Peter Roessling, Germany

“You have done fantastic work. Great! Congratulations, fantastic organization and high class. To see you in Singapore I could feel like I am at home. Wherever you go with your conference it is always a big success! Thank you for putting all professionals into your conferences.”.

– Bruno Cyglewicz, Dubai.

“Happy and completely satisfied, thank you for the great organization”.

– Jacky Dijk, The Netherlands

www.capp-asia.com Singapore
The “Current Concepts in American Dentistry”, international program was established at New York University College of Dentistry in 1981. This popular program now has over 3,500 graduates from 26 countries. These customized educational opportunities are designed for international dental groups to provide a deeper knowledge and understanding of specific areas of dentistry. The teaching staff includes NYU College of Dentistry faculty, alumni and outstanding educators from other institutions and private practice. Program topics and content are determined by the special needs of the group in consultation with the Assistant Dean for Continuing Education.

In addition to lecture and clinical observations, participants are required to complete a written report based on two clinical cases in their private practices. All programs are in English. To maximize the learning experience, sessions in New York City are limited to a minimum of 25 and a maximum of 50 participants. Individual dentists not part of a group may join an existing group on a space available basis and with prior approval of the Assistant Dean for Continuing Education. Attendance in New York City is mandatory in fulfilling the program requirements.

Five sessions of which three weeks of attendance must be at New York University College of Dentistry in New York City. Also, two additional sessions must be completed either at New York University College of Dentistry or at any of our international programs scheduled at locations throughout the world. Participants are encouraged to complete the program in a timely fashion recommended not to exceed two years. During the final week at New York University College of Dentistry, participants are required to document and formally present two clinical cases performed and completed in their private practices. This final written report with the two clinical cases must be referenced with appropriate scientific literature. Recommended report length is 10-15 pages. This report may be in English or another language if English is not the language selected a one-page summary in English must be included.

Upon successful completion of all program requirements, a certificate of achievement will be awarded by NYU Linhart Continuing Dental Education Program. The final decision on meeting all requirements is the responsibility of the Assistant Dean for Continuing Education.
CAPP and New York College of Dentistry start Middle East Program 2012 - 2013

By Dental Tribune Middle East & Africa

ABU DHABI, UAE: “Current concept in American Dentistry” course kicked off together with official partner with Center for Advanced Professional Practices (CAPP) successfully on October 11, 2012 in UAE. 22 Dental Specialist from 8 countries attend for the session in Abu Dhabi, the first from the total 5 sessions. This international dental program is specially designs to meet the educational needs of dental group to “learn from the experts”. The program has total of 5 sessions – 2 in Middle East and 3 in New York City - NYU College of Dentistry. Through informative and stimulating lectures, interactive group discussions, treatment planning sessions, “live” patient demonstrations and participant written reports and clinical case requirements, this practical and innovative learning approach will expand your horizons and increase your confidence in pursuing clinical excellence.

Dr. Dobrina Mollova
Managing Director
info@cappmea.com
Center for Advanced Professional Practices

“Current concept in American Dentistry” course was kicked off together with official partner with Center for Advanced Professional Practices (CAPP) successfully on October 11, 2012 in UAE. 22 Dental Specialist from 8 countries attend for the session in Abu Dhabi, the first from the total 5 sessions. This international dental program is specially designed to meet the educational needs of dental group to “learn from the experts”. The program has total of 5 sessions – 2 in Middle East and 3 in New York City - NYU College of Dentistry. Through informative and stimulating lectures, interactive group discussions, treatment planning sessions, “live” patient demonstrations and participant written reports and clinical case requirements, this practical and innovative learning approach will expand your horizons and increase your confidence in pursuing clinical excellence.

We try to use the knowledge that we have to share with the rest of the world to make dentistry easier and more predictable and to make dentists have a more enjoyable time in their private practice.”

H. Kendall Beacham
Assistant Dean
Linhart Continuing Dental Education Program
New York University College of Dentistry

“We have to be sure that the technology that’s developed is useful, and then if you apply that technology it should not be via a commercial company, it should be via educators that need that to work under certain set of circumstances.”

“They’re a great course, we enjoyed every moment, it’s very nice and we recommend everyone should come to this course”

“We really believe that dental knowledge belongs to the world”

“This is a great atmosphere for learning, and this is the boom circuit for people in this industry to start understanding and learning this kind of dentistry so they can bring it to their patients”

“This has been a great group, they have a wide range of information and knowledge and skills”

“I strongly would recommend coming back here, and I’m very excited to come back again too”
BUFFALO, N.Y.: “We have friends in Syria who were visited by police because their son had attended a rally. When they told the police that their son wasn’t home, the police proceeded to shoot the three children who were there, in front of their mother, as a warning. One of those children was three years old.”

This is just one of the many stories about conditions in Syria told by Othman Shibly, DDS, MS, assistant professor in the Department of Periodontics and Endodontics at the University at Buffalo School of Dental Medicine. According to recent news reports, when the United Nations withdrew its observers in Syria in June, deaths increased by 78 percent; in July they went up another 55 percent; and then up near-

ly 48 percent in August to more than 5,000. Deaths of Syrians are now in excess of 30,000 since the rebel uprising began in March 2011.

Syria was Shibly’s home country; it is where he still had family. He wanted to contribute to helping those Syrians who had been displaced and injured and are now living in the Turkish refugee camps. On June 29, he went to Turkey to attend an academic conference in Istanbul and during the second week of his visit he went to one of the camps — the Kilis Refugee Camp next to the Syrian Border in Gaziantep City in Turkey — and spent a week assessing the oral health needs of those who had escaped from the Assad regime. At the time, the camp had 11,000 people.

Shibly had anticipated a great deal of need but what he found shocked him. “There were people with broken or infected teeth — this I expected. But that’s not all. There were people who had been injured by having soldiers push the end of a rifle into their teeth; people with broken jaws. People with injuries to the face. So many people. Some of these were children,” said Shibly.

Shibly knew that one visit wouldn’t be enough to address the all the problems. The camp needed a dental clinic with trained personnel to help with oral health and injuries every day.

Shibly said that when he returned to Buffalo, to UB, he put together a plan. First, he determined the costs needed to purchase enough dental equipment for two camps. It would take from $70,000 to $100,000 per camp.

When people heard Shibly’s stories they wanted to help. He was able to raise $15,000 from friends’ donations in Western New York and received $30,000 from dentists in Waterloo, Ontario. And when he told another group of friends and associates that he was $5000 from his goal, they told him not to worry: they had the rest of the money.

Shibly has just sent the donated funds through a charity to a dental company that sells their equipment in Turkey (the dental company discounted the merchandise in support of this humanitarian cause). Once the instruments arrive, Shibly will travel back to the Turkish camp this fall with his colleague, Fadi Ayoub, UB assistant professor of restorative dentistry. Syrian medical relief workers will provide a place within their medical centers in the camps to set up the dental clinics.

Shibly and Ayoub will then work with Syrian camp refugees — who are also dentists — to have them run the clinic’s day-to-day dental operations for an allowance, and both of them will return about every two months on a rotational basis. A team from the Syrian Medical Society and the Islamic-American Medical Society is also collaborating with Shibly and Ayoub in their clinical rotations.

Additionally, Shibly is organizing a schedule for American dentists to choose the times they wish to donate care so that the clinics are always adequately staffed.

“We have to go back because there is so much work. As a periodontist, I can do oral surgery. I can also bring oral surgeons under whose guidance I can perform specialized procedures,” Shibly said.

While Shibly is elated to have raised such a large amount of money in such a short time, the conditions that surround his volunteer initiative weigh heavily on him.

“From a humanitarian perspective, the United Nations has failed. And the world community just watches. They have given money, which is appreciated, but it’s like giving Tylenol to a cancer patient for pain relief. It’s not enough.”

“The world has not learned its lessons from the atrocities of the Holocaust, Bosnia, Somalia and Rwanda. How many must die before there is intervention,” he said.

Then his voice softens as he speaks with thanks and admiration about the orthopedic surgical resident who put his training on hold to go to Syria to provide medical care, working for nothing, and the Syrian-American pharmacist who brought her whole family with her — her children scrubbing the floors of the pharmacy — while she provides her expertise for free.

“So even out of bad there is some good,” Shibly said smiling.

(Source: University at Buffalo School of Dental Medicine)

Professor to launch dental clinic in Turkey to treat Syrian refugees

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