DANAHER opens MEA Office in Dubai Healthcare City

By Dental Tribune MEA

Dubai, UAE: Danaher is a global science and technology innovator committed to helping its customers solve complex challenges and improving quality of life around the world. Its family of world class brands have unparalleled leadership positions in some of the most demanding and attractive markets, including health care, environmental and industrial. The company’s globally diverse team of 66,000 associates is united by a common culture and operating system, the Danaher Business System. In 2013, Danaher generated $19.1 billion in revenue and its market capitalization exceeded $50 billion. For more information please visit www.danaher.com.

Dental Tribune MEA had the pleasure to attend the opening of the Danaher MEA offices at Dubai Healthcare City and shortly interview James Lico, Executive Vice President Danaher and Alex Joseph, President Middle East and Turkey, Danaher Corporation on their thoughts for the region.

What does the opening of the MEA office in Dubai Healthcare City mean for Danaher?

A. Joseph: The opening highlights our commitment to the Middle East and is the direct result of the growth we are experiencing in the region.

And how important is it for you to have an office in Middle East and Africa?

J. Lico: As Alex mentioned, the region is incredibly important for us. Unlike many companies who focus on just selling to the region, for us it is important to be close to customers and build up the capability of our team locally so we can serve customers. The opening of this office really proves we not only want to do business in the region but invest in the long run to serve our clients.

Regarding your dental companies, Danaher celebrates together with the Dental Division the opening of the new MEA office.

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A. Joseph: Our dental business has been a major contributor to our growth in the region. There is a big focus on dental care in the Middle East. Through our broad dental product portfolio and leading brands such as KaVo, Kerr and Ormo to name a few, Danaher serves customers across all segments – from dental instruments, to treatment centers, to imaging equipment, to orthodontic technology and services, to dental consumables – so we have a full gamut and we believe that we provide our customers the highest quality dental products and solutions that serve 90% of dental practices throughout the world.

Can we expect to see more dental companies joining Danaher?

J. Lico: Well, we never comment on acquisitions but I think as Alex said that the dental market is a growth platform within Danaher. Our commitment to the dental market and our customers has been seen both in our organic and inorganic investments over the years. We have recently announced our latest addition to our dental segment with the acquisition of Nobel Biocare which closed beginning of December 2014. Looking into the dental business, there are probably no better examples of investments than investing in high growth market parts of the world. The Middle East is no different and our dental team here has really done an outstanding job over a number of years investing in products, technology, sales and services resources to make sure that we can really deal with the growing customer base that exist in the region. Obviously, investing here in Dubai is a Danaher investment but it can very much be seen as an investment in our growth platforms, of which dental is a key component.

What do you expect from your biggest media partner in dental here in the region in the coming year?

J. Lico: Any partnership which can continue to reach our customers in a creative, innovative way is positive for us and we ask this from every partner in all of our industries. Extending our ability to communicate to our growing customer base is an important part of our success in the region.

A. Joseph: Thank you for coming and joining us for our grand opening.

Dental Tribune: Thank you for the opportunity to interview you.

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IYADH, KSA: This is your second SDS Conference for you as President, what are your thoughts of the upcoming event in relation to previous?

The Saudi Dental Society (SDS) International Dental Conference last year paved the way to the first paperless event for the society where we introduced the Kavo which is a technology that utilizes Near Field Communication (NFC) technology to allow the exchange of online social networking data between two keychain accessories. Participants were able to interrelate professionally and exchange ideas during the conference activities digitally through their opened devices. The membership of the SDS continues to grow and each event has been a success, as in the previous year. This year, the event will feature 20 outstanding clinicians and dental experts who will cover various dental topics and bring forth another unique experience to its numerous members.

How do you reflect back over the last 2 years as president of the SDS?

During my first year, I had vowed to perform my tasks aimed at developing the society’s vision and to implement these policies and procedures. I am humbled to state that during my 2 years as President, the SDS served the dental community with many meaningful and remarkable accomplishments. I had hoped to stimulate more participation for the members of the Society towards providing them a better and diversified service, education and support.

We see more and more the SDS has become very active outside of the Kingdom, could you elaborate on your involvement in Dentistry for the GCC region?

The membership of the SDS is by far one of the largest in the GCC region. This is why some of the SDS Board members are always involved in the GCC conference organizing committee and a majority of its members are always actively participating in the conferences outside the Kingdom like Dubai, Kuwait, Beirut, etc. The commitment and presence of the SDS members in the GCC conferences ensures their support and they gain scientific and educational
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**Topical fluoride varnish with Calcium and Phosphate for the effective treatment of hypersensitivity**

By GC Europe

The Digital Dentistry had been introduced many years back but only a few keen users have adopted it until recently when many more dentists had found it better and convenient to use. Many more dentists had found it better and convenient to use. The dental community in the Kingdom has adopted to using these current digital techniques and workflows. They are now familiar to their learning experience and the impact of the new technologies in the dental community.

What advice do you have for the younger generations?

I am encouraging the younger generations to focus their professional ambitions by being committed to obtaining educational advancement to ensure their success and not to forget to share their services to the community.

Is there anything else you would like to share with the readers?

I am urging everyone to continue to contribute in terms of support, services and goodwill for a better community.

References

GC trademarks: Tooth Mousse, MI Paste Plus, Saliva Check Buff er, Saliva check Mutans, GC Tri Plaque ID Gel

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Dr. Mohammad I. Al-Obaida - President of The Saudi Dental Society

Visit the brand new Swiss Pavilion at AEEDC 2015 in Dubai

The Swiss Pavilion is organized by the Swiss Dental Industry Association (ASDI) with the support of Switzerland Global Enterprise (S-GE).

For more information about the association and its members please visit the ASDI welcome desk on Booth B812.

www.swissdentallabindustry.ch
General Dental Practitioners Lecture Series
Dubai College of Dental Medicine
Mohammed Bin Rashid Academic Medical Center

Speakers:

Professor David Wray
Dean of the DCDM
Professor of Oral Medicine.
Dubai College of Dental Medicine

Date: January 05, 2015
Time: 07:45 pm – 08:30 pm

Lecture 1
Dental Prescribing

Dr. Iyad Hussein
Assistant Clinical Professor/
Specialist in Paediatric Dentistry and Dental Anxiety.
Dubai College of Dental Medicine

Date: January 05, 2015
Time: 08:45 pm – 09:30 pm

Lecture 2
The neglect and abuse of children: prevention, detection and management. What is our role as healthcare professionals in the modern age?

Dr. Shazia Naser-Ud-Din
Assistant Professor Orthodontics
Dubai College of Dental Medicine

Date: February 02, 2015
Time: 07:45 pm – 08:30 pm

Lecture 1
Treatment Planning In Orthodontics-a Systematic Approach

Dr. Manal Al Halabi
Postgraduate Program Director of Pediatric Dentistry
Dubai College of Dental Medicine

Date: February 02, 2015
Time: 08:45 pm – 09:30 pm

Lecture 2
The Child Friendly Dental Practice, A Myth Or A Fact?

For online registration please visit: http://events.dhcc.ae
For inquiry, please contact Ms. Rose Clemente
Email: CPDevents@dhcc.ae
Office No. +971 4 3622861

Mohammed Bin Rashid Academic Medical Center
From everyday dentistry to advanced photoacoustic endodontic applications (PIPs): Er:YAG & Nd:YAG dual wavelength laser

By Lawrence Kotlow, DDS, Enrico DiVito, DDS, and Giovanni Olivi, MD, DDS

Lasers provide an exciting new technology that allows the dentist the ability to give patients optimal care without many of the “four factors” found in conventional dental techniques. Used with proper understanding of laser physics, lasers are extremely safe and effective.

Using lasers for caries removal, periodontal treatment, endodontic treatment, bone management, cutting and shaping, and soft-tissue procedures can reduce postoperative discomfort and infection, and provide safe, simple, in-office treatment. As a result, we can improve our efficiency, expand what we can do, achieve better results and increase production.

Lasers represent a real quantum leap forward in the treatment of our patients, including the pediatric patient. The U.S. Food and Drug Administration (FDA) gave approval for the use of the Er:YAG laser in 1997 for both hard- and soft-tissue procedures. The erbium-garnet laser’s erbium (placed within the YAG crystal) crystal of Yttrium-Aluminum-Garnet’s (Er:YAG) development and success has made the treatment of children safer and quicker.

Plainly stated, a laser is a piece of equipment that creates a concentrated monochromatic beam of visible or infrared light that can be absorbed by a specific target. By laser, we mean your laser efficiently, you will discover that many of these are procedures that every dentist can easily complete.

The question that is often the major concern and barrier to investing in lasers is the how this investment will pay for itself. It is recently described as return on investment (ROI). Will it pay for itself? We prefer to speak of this as the secondary effect. If you understand your laser, it will easily pay premiums on your investment, and the cost factor becomes a non-issue.

The purchasing of lasers is an investment, not an expense, for any dental practice.

Lasers represent a fundamental change in the entire way dentistry has been taught. We can now rethink and modify G.V. Black’s principle of extension for prevention with the concept of minimally invasive dentistry. We need to understand that laser dentistry is one portion of an entire new way of practicing conservative, pain-free dentistry.

The laser that we call the “all-purpose” laser is the Lightwalker Er:YAG & Nd:YAG laser, manufactured by Fotona and distributed in the United States by Technology 4 Medicine. The Er:YAG produces its effect at 2900 nm and has as its primary target water and hydroxypatite. It is very safe, relatively quiet, eliminates the smells and vibrations associated with the dental handpiece and, most importantly, is much more comfortable for the patient, significantly reducing the need for local anesthetics.

The use of the new generation erbium lasers for repair of incessant hard tissue diseases allows the dentist to provide a stress-free means of restoring teeth, ablate bone and treat soft-tissue abnormalities and diseases. An entire new standard of care is becoming available to patients.

Lasers and pediatric dentistry are becoming a reality. Understanding of laser physics, dental techniques. Used with proper understanding of laser physics, lasers are extremely safe and effective. Lasers and pediatric dentistry are becoming a reality.

PIPs for 20 seconds. (Photos/Provided by Technology 4 Medicine)

Figs. 1-2. Representative sample images of root canal dentinal walls irrigated with 17 percent EDTA and PIPS.

Er:YAG Laser 2900 nm: Soft-tissue procedures

There is a wide array of soft-tissue procedures that can be completed using the all-purpose laser: maxillary and mandibular frenum resections, gingival margin resections, treatment of pericoronary pain or infection, removal of hyperplastic tissue because of drugs or poor oral care in orthodontic patients, biopsies, treatment of aphthous ulcers and herpetic labialis, pulpotomies, removal of impacted teeth, and, in adults, apicectomies and bone contouring.

Pulpotomies

Parents often express concern about the need to take radiographs because of the nature of X-rays and their possible side effects on a child’s overall health. They question the use of alloys because of the chemical makeup of the alloy. Whether these should be a real concern in today’s dental care is open to debate, depending on your individual beliefs. There are also concerns by many, although not as loudly, about the effect of various pulpotomy procedures on the body in pulpotomy procedures, such as conventional.

Lasers provide a safe, non-ionizing, effective and alternative treatment for pulpotomies. During the span of eight years, post-treatment results on more than 4,000 pulpotomies using the erbium (2900 nm) laser provide ample evidence that this method is both effective and safe for children without the need for introducing chemicals or using electrocautery methods. When the final result of orthodontic positioning of the front teeth results in gingival hypertrophy, the laser can be a useful tool to increase crown length and give the patient a more esthetic smile. This may often be accomplished without the need for local anesthesia. Patients who have medically induced hyperplastic tissue, such as patients requiring dilantin, can also have their tissue reduced and reshaped with the erbium.

In addition to the many examples described in this article, lasers can be used for additional procedures not usually required in pediatric dentistry, such as revisions of the abnormal mandibular frenum, often avoiding the need for soft-tissue grafts, crown-lengthening procedures where bone requires recontouring, apicectomy, removal of bony exostoses, removal of third molar impactions, removal of root remnants, incising and draining soft-tissue infections, advanced periodontal treatments and the latest in advanced endodontic treatment via photoninduced photoacoustic streaming.

Photoacoustic endodontics using PIPS

The goal of endodontic treatment is to obtain effective cleaning and decontamination of the smear layer, bacteria and their byproducts in the root canal system. Clinically, traditional endodontic techniques use mechanized instruments, as well as ultrasonic and chemical irrigation, in an attempt to shape, clean and completely decontaminate the endodontic system but still fail short of successfully removing all of the infective microorganisms and debris. This is because of the complex root canal anatomy and the inability for common irrigants to penetrate into the lateral canals and the apical ramifications. It seems, therefore, appropriate to search for new materials, techniques and technologies that can improve the cleaning and the decontamination of these anatomical areas.

Among the new technologies, the laser has been studied in endodontics since the early 1970s and has become more widely used since the ‘90s. Different wavelengths have been shown to be effective in significantly reducing the bacteria in the infected canals, and important studies have confirmed these results in vitro. Studies reported that near infrared laser are highly efficient in disinfecting the root canal surfaces and the dentinal walls (up to 786 microns for the diode 980 nm and up 4 mm for the Nd:YAG 1064 nm). On the other hand, these wavelengths did not show effective results in debrid- ing and cleaning the root canal surfaces and caused characteristic morphologic alterations of the dentinal wall. The smearlayer was only partially removed and the dentinal tubules primarily closed as a result of melting of the inorganic dentinal structures. Other studies reported the ability of the medium infrared laser in debridging and cleaning root canal walls. The bacterial load reduction after erbium laser irradiation demonstrated high on the dentin surfaces but low in depth of penetration because of the high absorption of laser energy on the dentin surface. Also the laser activation of commonly used irrigants (PIPs) resulted in statistically more effective removal of debris and smear layer in root canals compared with traditional techniques (U) and ultrasound (P). Additionally, the laser activation method resulted in a strong modulation in reaction rate.

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of NaOCl significantly increasing production and consumption of available chlorine in comparison to ultrasonic activation. A recent study has reported how the use of an Er:YAG laser, equipped with a newly designed radial and stripped tip, in combination with 17 percent EDTA solution, resulted in very low pulse duration (50 microseconds) and low energy (20 mJ) resulted in effective debris and smear layer removal and minimal or thermal damage to the organic dentinal structure through a photonic-acoustic technique called photon induced photonic-acoustic streaming or “PIPS.” Also the same photonic-acoustic protocol in combination with 5.25 percent sodium hypochlorite has been investigated and shown to reduce the bacterial load and its associated biofilm in the root canal system three dimensionally. Other similar studies are in progress for publication and the results are promising and suggest a three-dimensional positive effect of this laser activated decontamination (LAD) method.

The purpose of this article is to present briefly the experimental background of this laser technique and to introduce the clinical protocol. The microbiographic recording of the LAI studies suggested that the erbium lasers used in irrigant-filled root canals generate a streaming of fluids at high speed through a cavitation effect. The laser thermal effect generates the expansion implosion of the water-misticles of the irrigant solution, generating a secondary cavitation effect on the intracanal fluids. To accomplish this streaming, it is suggested the fiber be placed in the middle third of the canal, 5 mm from the apex and station ary. This concept greatly simplifies the laser technique, without the need to reach the apex and to negotiate radiicular curves. Also, the recorded video of the new technique, PIPS, showed a strong agitation of the liquids inside the canals. It differs from the already cited LAI technique by activating the irrigant solutions in the root canals through a powerful laser, using a profound photonic-acoustic and photomechanical phenomena. The use of low energy (50 microsecond pulse, 20 mJ at 15 Hz, 0.5 W average power, or less) generates only a minimal thermal effect. The study with thermocouples applied to the radicular apical third revealed only 1.2 degrees C of thermal rise after 20 seconds and 1.5 degrees C after 40 seconds of continuous radiation. When the erbium laser energy is delivered at only 50 microsecond pulse duration through a special designed tapered and stripped 400 microns tip (Fotona Light Walker, Technology4Medicine), it produces a large peak power of 400 watts when compared to a longer pulse duration. Each impulse, absorbed by the water-misticles, creates a central axis wavefront that leads to the formation of an effective streaming of fluids inside the canal while also limiting the undesirable thermal effects seen with other methodologies. The placement of the tip in the coronal portion only of the treated tooth allows for a more minimally enlarged canal preparation with less thermal damage as seen with those techniques placed into the canal system. The root canal surfaces irrigated with 17 percent EDTA and laser activated for 20 seconds showed exposed collagen matrix, opened tubules and the absence of smear layer and debris (Figs. 1-5). The rinsing with 5.25 percent sodium hypochlorite and laser irradiation for 20 seconds produced a strong activation of the solution, as reported by Maredia, 21 improving the disinfecting action of the sodium hypochlorite. The disinfecting action of PIPS is very effective both on the root surface, the lateral canals and the dentinal tubules, as confirmed with SEM and confocal studies (Fig. 4). The profound and distant effect of PIPS eliminates the need to introduce the tip into the root canal system. Unlike traditional laser techniques requiring placement of the tip 1 mm from the apex, or even 5 mm from the apex as proposed for LAI, 22 the PIPS tip is placed in the middle third of the pulp cham ber only and left stationary, allowing the photoacoustic effect to spread into the opening of each canal. A new tip design consisting of a 400-micron diameter, 12 mm long, tapered end is used for this technique (Fig. 3). The final 5 mm of coating is stripped from the end to allow for greater lateral emission of energy compared to the front tip. This mode of energy emission allows for improved lateral diffusion with low energy and enhanced photonic-acoustic effect.

Discussion Laser irradiation is a common technique used in endodontics to improve the cleaning, the debridement and disinfection of the root canal system. Wave- lengths and protocols are used. Near infrared lasers are used for the three-dimensional decontamination of the endodontic system. Nd:YAG and diode lasers use thermal energy to destroy bacteria. Observations reveal a certain grade of thermal injury to the root canal surface and create a typical morphological damage. Moreover, they are not able to thoroughly remove the smear layer. On the contrary, erbium lasers are used for their effective smear layer removal while their bactericidal activity is limited to the root surface. The placement of the tip close to the apex and its back movement during the activation process is related to the risk of apical perforation, lodging and surface thermal damage, because of the ablation ability of this wave- length. Also a combination of near and medium infrared lasers has been proposed. A technique, called twinline endodontic treat ment (TET), uses the erbium laser energy first, to clean the root canal surface and remove the smear layer, and the Neodimium:YAG laser second, used in dry mode as the final disinfecting step. All these techniques utilize traditional tips and fibers placed into the canal, close to the apex (1 mm) with all the corresponding thermal disadvantages observed in long, narrow and curve canals. The erbium lasers are also used as a medium of activation of commonly used irrigants (LAI), avoiding the risk of thermal damage, while increasing the cleaning and disinfecting activity of the fluids. PIPS, in particular, reduces all these risks and disadvantages, thanks to the position of the tip in the coronal orifice only and to the use of minimally ablative energy levels of 20 mJ or less.

The findings of our studies demonstrate that PIPS technique resulted in a safe and effective debridement and decontaminating of the root canal system. Our clinical trials showed that PIPS technique greatly simplifies root canal therapy while facilitating the search for the apical terminus, debridement and maintaining patency.

As a result of the efficacy of PIPS, the final size required for canal shaping can be significantly reduced, offered to a size 25/04, allowing for a more minimally invasive and biologically active treatment that can then be obturated three dimensionally.

Conclusion Lasers are an extremely versatile addition to the dental practice and can be used in many instances instead of the conventional methods employed by the vast majority of dentists. Incorporating a laser in the dental practice should be viewed as an investment rather than a cost. When used with a good knowledge of laser physics, training and safety, lasers provide our patients a new standard of care.
Simplification at its best

By Thorsten-Simon Eickholt, 3M ESPE, Seefeld, Germany

Is there a need for another posterior restorative in dentistry? Clearly, the answer is yes.

What is desired is a product that offers the mechanical properties of products like 3M™ ESPE™ Filtek™ Supreme XTE Universal Restorative are familiar with, but allows for a more time-efficient placement procedure.

For this purpose, 3M ESPE developed the new 3M™ ESPE™ Filtek™ Bulk Fill Posterior Restorative. The material contains true nanotechnology and is available in five shades. It may be placed in increments of up to 5 mm, but if desired, a layering technique is also possible. In combination with the fact that the new material does not require a covering composite layer and is easily sculptable right after placement, this ensures a fast and easy filling procedure ideal for all kinds of posterior restorations.

Reducing shrinkage stress

Traditionally, a reduction in shrinkage and shrinkage stress has been accomplished by optimizing the filler composition as in Filtek Supreme XTE Universal Restorative. This restorative uses an innovative filler technology with silica and zirconia particles and clusters. The shrinkage inherent to any methacrylate matrix is low in this material and does not compromise its clinical performance when placed in layers of 2 mm.

In order to allow for increments of up to 5 mm in Filtek Bulk Fill Posterior Restorative, the nano-filler technology was adopted, but a different matrix developed. The composite contains a new aromatic dimethacrylate with high molecular weight (AUDMA) and a novel addition-fragmentation monomer (AFM). Due to AUDMA, the polymer matrix developing during polymerization obtains a higher flexibility. AFM changes the polymerization reaction: Typically, light curing causes chains of monomers to form and cross-link with each other, resulting in a polymer network. Those monomers which are closest to the light source react immediately and the chains grow from this point. The increasing rigidity and decreasing volume of the network cause stress to develop at the margins. In contrast, AFM contains an additional reactive site that enables cleavage of the forming molecular chains during polymerization. The obtained fragments are more evenly distributed so that the network relaxes and stress is prevented. Cross-linking again at a later stage, the final polymer structure is obtained.

Conclusion

The uniform network formation and the increased flexibility of the matrix result in a restoration that causes less shrinkage stress even when applied in 5 mm increments.

As a consequence, a tight marginal seal is obtained and the risk of post-operative sensitivities is minimized, while superior physical properties are achieved.

This was confirmed in initial tests: Properties such as the wear resistance and polish retention are similar to those of the proven Filtek Supreme XTE restorative. An excellent handling and 24% faster application time was revealed in a field test with European dentists*. In this test, 150 Western European practitioners put the new product head-to-head against their preferred restorative materials that require different placement techniques. The materials included incrementally placed composites as well as high- and low-viscosity bulk fill materials.

The result: 92% of the dentists would recommend the material to a colleague.

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*Comparison between Filtek™ Bulk Fill Posterior Restorative and Filtek Supreme XTE Universal Restorative. Measurement is performed by MRC (Medical Research Center) in Uffersbach, Germany.
One step placement. One innovative material. No expensive dispensing device. No time-consuming layers. Posterior restorations made simple.

Bulk fill composites are designed to make large posterior restorations faster and easier—however, productivity can be lost when using complicated layering techniques or expensive dispensing devices. Filtek™ Bulk Fill Posterior Restorative was designed to improve productivity by allowing one-step placement up to 5 mm … as easy as “one and done.”

www.3MESPE.com/Filtek
Translucent Full-contour Zirconia... Innovation in the dental industry

By Aiham Farah, Syria

Being able to Choose the same material for fabricating every single restoration in one case (whether they were bridges, full crowns or veneers) is always a big advantage, it serves in achieving the accurate matching and harmony among all the restorations in the following dimensions: (Value, Height, Clarity, translucency, depth, etc.). The challenge for the dental manufacturers have been always strength and esthetic level of the dental restorative material, finally we started testing new generations that combine both, but the question is still: Did we esthetically get to the level of the glass-based material such as Lithium Di-Silicate, the answer might be no, but perhaps we are close with the TYZ (Translucent Full-Contour Zirconia) for the long span bridges in the posterior region.

The pre-operative situation 56 year old lady presented to her consultation appointment at the dental studio asking to change her smile.

Her main concern was the extensive yellowish-brownish discoloration in her front teeth, especially the upper ones. Besides the miss old metal teeth set up that reflected older age effect on her face (according to her). She was a receptionist in one of the beauty & skin care companies in Dubai, and her overall look was important to her. (Fig. 1b, 2, 5)

Data collection and analyses

We evaluated the patient pre-operatively, went through her dental history, took many photos from different angles, and discussed her expectations and goals.

Intra-Oral Diagnoses

After the dentist diagnosed the case he reported the following: Seven tetracycline discoloration, lack of vitality, poor appearance, besides disproportional dimensions of the teeth proportions, and conflicting smile line with the curvature of the lower lip line. (Fig. 4)

Radiographic exam revealed a need for endodontic treatment for some of the posterior teeth.

Preliminary impressions were taken to have a study model for us to be our physical reference where we can draw our lines, straighten long axes, adjust length and do the cosmetic counterpointing, etc.

The need for DSP (Digital Smile Philosophy) in this case

Enrolling the photos we took on our PC screen and digitally redesign the teeth arrangement according to the lips movements and curvature in the means of (Digital Smile Philosophy), was necessary since our patient’s main complaint was the smile. (Fig. 1a)

There for, as a dental team, we should think further than esthetically reshaping each individual tooth. We should think more of relation between each tooth to the neighboring tooth next to it, from one hand, and to the harmony between the entire teeth arrangement and the lips movements, on the other hand. (Fig. 1b)

The Philosophy of redesigning the smile digitally

Through a simple software (power point Dr Keystone), we can edit our photos based on our knowledge in the dento-facial esthetic and harmony. To have more sufficient ways of communicating between the clinic and its laboratory on one end, and for our patient to visualize our final outcome whether it meet his/her expectation of the whole treatment or not.

So the dentist will not go over- invasive in his/her treatment of the patient teeth anymore, neither the dental technician will have to guess in creating the shape and measurements of his/her final restorations. But they both will follow a interdisciplinary plan where results are controlled and expected according to a preapproved-by-patient mock up test. The trick is that we need to make our measurements on our PC screen match the real measurements on our patient teeth and their replica of a cast stone model, thereafter we develop a digital roller, which measures distances on the PC. This will be our communicating tool between the digital world and the real world.

Then we calibrate our photos according to it (shrink & stretch), for any editing done on the photos from lengthening to shortening etc, will be able to be measured using our digital roller and these measurements can be used by the dental technician to fabricate his esthetic diagnostic wax-up. (Fig. 4, 5, 6, 7)

Choosing the tooth contour for our ceramic

No link has been proven 100 percent, between the face and tooth contour, and no certain rule has been followed to simplify the mission of choosing the fabricated restoration contour.

However, some theoretes have been put into good use, most of them rely on the physical facial analysis from all over contour and rounding. The rest rely on the morpho-psychology and emotional features of the patient.

The question still is whether the original tooth shape, that our patient was born with, is what we need to go back to when we design our restorations, OR a NEW tooth shape is what we need to improvise, that might add up on the patient character. (Fig. 8, 9)

Preliminary treatment and preparation

6 upper anterior were prepared according to the general principles of preparing all-ceramic Veneers, 0.9 mm buccal reduction was given, taking the degree of stump discoloration and final shade approached into consideration. 1 mm bevel preparation was prepared at the incisal edge, and 0.6mm rounded shoulder (almost 1-1.5 mm subgingival).

8 lower anterior and one additional premolar were prepared according to the general principles of preparing porcelain laminate veneer, 0.5 mm buccal reduction was given with a 0.4 chamfer (equusivagually).

2 bridges were prepared in the posterior region, one on the upper jaw, one in the lower jaw. (Fig. 10)

Final impression was made using additional silicone (Virtual, Ivoclar Vivadent). Shade of the prepared teeth was also taken using the natural die material shade guide (from Ivoclar Vivadent) and reported as ND6, which needed a special caution choosing the ingot level of (Translucency – Opacity), in order to mask this discoloration and reach the bleach B1.4 shade (according to the patient need). (Fig. 11) shows the bleach shade guide, in color comparison with the ND situation).

Direct temporary restorations were made with the aid of an index. No signs or symptoms of discomfort were observed or reported over two weeks. The periodontal situation was kept under surveillance, and the healing process of the gingival tissue was clear, in means of color and positioning. At the same time, those restorations were our patient’s future look, so adjustments in shape at this stage can still be conducted intraradly by carving or adding composite resin on to reach adequate harmony among lips, smile and face character.

Lab tribune

The challenge of combining Zirconia to e.max in the same case.

Explained in details in Lab Tribune page 10

Working technique Restriction:

Our lab working techniques for characterizing a pressed set of veneers are either staining technique, cut back technique, or layering technique. But in combination cases where we
have glass based veneers (SiO2) and Zirconia based Full Contour bridges in the same case, the scenario is different, and our working options are minimized to have mostly the staining technique working protocol to conduct simultaneously on both the veneers and the bridges. In order to guarantee that both materials react to light as close as possible to themselves, so shade dimensions (Hue, Value, Chroma) in both materials can almost match. (Fig. 17) That scenario is valid mostly when the required final shade is one of the bleach shades, then the ratio of translucent enamel is pretty much relevant to the patient desire, but majority of patient who ask for a bleach shade are concerned about showing a high brightness of their smiles rather than showing a natural looking translucency on the incisal third.

Staining technique will prevent us from layering feldspathic ceramic (enamel) on top, which leaves the glass LiS2 exposed, that allows more light and brightness to radiate from the pressed material, at the same time that would lessen the esthetic look of a natural tooth, but the question again is: what does our patient need? And what category of patient he/she is? He/she wants to bring teeth back to their natural look? Or he/she wants bleach teeth with no translucency graduation. (Fig. 18, 19: note the matching, after final cementation, between the IPS e.max press & the Zenostar Zr.

I realized that finally found my robust restorative material for long span bridges in the posterior region that I can combine to the IPS e.max material without any risk of hesitation, thanks to the innovative TFZ Zenostar.

Cementation and follow up:
E.max veneers were finally cemented using VarioLink II (Ivoclar Vivadent resin cement-adhesive cementation technique), then Zenostar posterior zirconia bridges were followed using the same VarioLink II base mixed with catalyst, after the cementation surface had been blasted in the lab with AL2O3. Finishing and polishing rubber heads (OptraFine Assortment, Ivoclar Vivadent) were used to remove excess residual cement and to eliminate all occlusal interferences. During the follow up appointment, a final checkup and modifications were made to eliminate all occlusal interferences. (Fig. 20 – 25)

Conclusion
After that outstanding match I had between the IPS e.max press & the Zenostar Zr.

After that outstanding match I had between the IPS e.max press & the Zenostar Zr.

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A new method for direct composite restoration of the posterior teeth

By Prof. Luca Giachetti, MD, DDS, MSc Department of Dentistry, University of Florence, Italy

Introduction
The evolution of composite materials and adhesive techniques has considerably changed the approach to restorations in posterior areas. The advantages of adhesive restorations are not only of an aesthetic nature, but, above all, relate to the possibilities of conserving a greater amount of healthy tissue and “reinforcing” the residual dental structure.

However, to exploit these advantages fully, we need rigorous clinical procedures which can limit what has always been the main flaw of composite materials: the polymerization shrinkage and the resulting stress which is responsible for most clinical failures.

Manufacturers have focused their efforts on producing materials which are ever easier to use and which, at the same time, are able to minimise their associated problems.

The recent introduction of the SonicFill™ System follows this direction. SonicFill combines the attributes of a low viscosity composite and a universal composity. By activating the composite with sonic energy, it is possible to fill the cavity and adapt the low viscosity material easily, and then compact and model it while the composite changes its consistency until it reaches a higher viscosity.

The manufacturer claims that it has the advantages of being:
- Fast: working time is reduced; it is possible to carry out single interventions to an individual maximum thickness of 5 mm.
- Reliable: reduced shrinkage and good adaptability to the cavity walls due to the low initial viscosity.
- Easy: it is possible to deliver the material using a small-diameter cannula and foot switch control.

We present a clinical case below in which direct restorations have been produced with SonicFill on 3 elements of the 1º quadrant.

Clinical Case
Male patient, with an acceptable level of oral hygiene. In the maxillary right posterior quadrant, several deteriorated amalgam restorations are present with signs of marginal infiltration compatible with the age of the restorations, and signs of wear and tear in the zones of interocclusal contact. Tooth 1.5 has primary decay on the distal aspect of the tooth. The treatment plan was to replace the old amalgam restorations and to treat the primary caries with direct composites.
Conclusion
The possibility of filling cavities to a depth of up to 5 mm with a single delivery effectively speeds up the work of performing composite restorations. The SonicFill composite presents good marginal adaption and is non-sticky. Once the sonic vibrations stop, it takes on an ideal consistency for modeling, and easily maintains the imposed shape. From an aesthetic point of view it is perhaps a little translucent to allow a greater depth of polymerization; however, it is possible to apply Kolor Plus® tints to make the restoration look natural. Ultimately, if the long-term controls show that the integrity of the margins is maintained, we will actually be able to confirm that we have accomplished a significant step towards simplifying direct restoration procedures with composite materials in posterior areas.

The products that appear in conjunction with this article are for illustrative or informational purposes only. Their inclusion does not denote endorsement by the author of this article.

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Prof. Luca Giachetti graduated in Medicine and Surgery in 1983 and specialized in Odontostomatology in 1986 at University of Florence Medical School. Msc in Dental Materials in 2009 at University of Siena Dental School. Chair of Dental Materials and Restorative Dentistry, University of Florence Dental School. Director of post graduate courses in aesthetics and adhesive dentistry, University of Florence Dental School. Dental Chief of Staff of Conservative Dentistry, Careggi Hospital-University, Italian NHS, Florence. He is member of the faculty in the International PhD program “Biotechnology and Dental Biomaterials” at University of Siena Dental School. Associate Fellow in Education & Development, Warwick Dentistry, The University of Warwick, Coventry, UK. He has lectured at congresses and symposia and published on dental adhesives and composites in international dental journals. He runs a private practice in central Florence.
Jordan toothbrushes are designed for excellence

By Jordan

Over the years Jordan has received numerous awards for design excellence, also for their unique range of children’s toothbrushes, Step by Step.

Jordan is a Scandinavian brand of oral care products that are distributed globally. Depending on the region they can be found in food, drug or pharmacy outlets. The company was founded in 1837 and started production of toothbrushes already in 1927. Today Jordan is the market leader in toothbrushes and dental floss and sticks in the Scandinavian markets and has a strong presence in many markets worldwide, including the United Arab Emirates.

Jordan products are made with quality, safe materials and are designed for performance and comfort. Motivating usage is important to Jordan and encouraged in all their ergonomically designed products. Jordan has a range of products to suit the different physical and aesthetic preferences of the global consumer.

Jordan’s Step by Step range of toothbrushes has been the best-selling children’s brush in Scandinavia, and many other markets, since the launch in 2006. GeriljaWorks designed the two toothbrushes for children aged 2 years and up. “For us the development of the brushes was a fun challenge. In addition to making dental hygiene enjoyable, it was especially important to maintain optimal user-friendliness for both parents and children,” says Markus Hoy-Petersen of GeriljaWorks.

The iconic shape of Step 1 has been an international breakthrough in children’s toothbrush design. It is designed for both parents and babies to hold and navigate around the mouth. “Playful design that really works is fundamental in our mission to create good brushing habits that will keep teeth clean and healthy for life,” says Michelle Wentworth (International Marketing Manager for Jordan).

“We know that one in five five-year-olds, along with over half of all 12 year-olds, have cavities. While the authorities have put the spotlight on diet and sugar consumption among children, Jordan wishes to put good routines for dental care on the agenda. By introducing toothbrushes that are carefully adapted for each age group - both in terms of functionality and motivation - Jordan seeks to inspire children and their parents to improve their children’s dental health,” says Mrs Wentworth.

Jordan’s Step series is a range of toothbrushes specially developed to best meet the challenges of children from 0-9. Children undergo extreme changes both physically and emotionally and the different toothbrushes are designed to perform well and also to teach children important oral care habits along the way. For example Step 2 is designed for children aged 5-5-5 and encourages children to brush for 2 minutes with its built in timer.

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“ar Dot Award – Step 1 toothbrush

By Dental Tribune MEA

Dubai, UAE: Sirona in collaboration with Centre For Advanced Professional Practices organized the first of its kind, CEREC DETF last September in Dubai. Dental Tribune MEA interviewed Dr. Amro Adel - Area Manager GCC & Pakistan, Country Manager Saudi Arabia for some feedback on the event and the plans for Sirona in 2015.

Dental Tribune MEA: Dr. Amro, congratulations on yet another successful year. The highlight of the year must have been the CEREC Desert Fest. How do you reflect back on this unique event for Dentists & Dental Technicians?

Dr. Amro Adel: CEREC Desert Fest in Dubai was a dream project to work on together with the successful collaboration of CAPP. It took us 5 years to decide the concept and it proved its worth. It became a concept of bringing a variety of CEREC expertise from various parts in the world to Dubai to present their experience and share the knowledge of CAD/CAM & Digital Dentistry. Our target group were Dentists and Dental Technicians from the region and we invited current and future users to register. CAPP was our trusted partner due to our long lasting partnership in the area over the past decade. They have the right experience in bringing the latest education in dentistry to the end-users. We have cooperated with CAPP since the 1st CAD/CAM & Digital Dentistry Int'l Conference 10 years ago in Dubai. The Desert Fest is the first step in the foundation of bringing a concept of CEREC events in the region on yearly basis. This year was the CEREC Desert Fest, in the years to come we will showcase...
A decade ago Sirona took part in the 1st CAPP event in the region, what was it like?

During the 1st CAD/CAM & Digital Dentistry Int’l Conference we started with 180 delegates, one old model CAD/CAM machine without a stand and in 10 years time Sirona is the biggest company representing the topic of CAD/CAM & Digital Dentistry in one of the biggest hotels in Dubai – Jumeirah Beach Hotel. We will keep on going, continue to improve and deliver the best, we learn from our mistakes and we listen to the feedback of our past, guests and clients to bring them always the latest in dentistry. It is my pleasure to see that the CEREC users in the region welcomed the topics we have offered and that they are focusing more on advanced courses and hands on showing demand for knowledge. They are interested to take advantage of CEREC and help their practices grow while providing top notch quality to their patients.

Dedicated practical courses are in demand for dentists and dental technicians. How will you supply this?

At Sirona it is always important for us to reach the needs of the client and focus on showing potential user how they can benefit. For these reasons we are planning to have beginner and advance courses throughout the year during the main events where we are present such as the CAD/CAM & Digital Dentistry Int’l Conference in May as well as the Dental Facial Cosmetic Int’l Conference in November, both in Dubai. This was the feedback from the CEREC Desert Fest event. The thought behind the concept was taken during the CEREC Desert Fest. We brought together several school concepts including American School (Dr. Todd Ehrich, USA and Dr. Daniel Vasquez), the German school (Prof. Wael Alt, Germany and Dr. Bernt Reiss), the Czech school (Dr. Josef Kunkela, CZ) who all provided their experience and knowhow through their panel show presentations and hands-on workshops. There are different ways in approaching the way the CEREC software runs and in different parts of the world this is presented differently. Starting with the American approach delegates were able to understand how fast they can enjoy a return on their investment with facts including hints and tips. Followed by the German approach which was more focused on understanding the software in a professional way and making sure you use all possibilities of the software and understand the science behind the software which was ‘Made in Germany’. We also managed to bring the President of the Czech Society of CAD/CAM Dentistry who delivered a fantastic concept on Smile Design sparking up interests and discussions on designing anterior cases to improve patients function and esthetic. Dental Technicians also enjoyed a full day program with which took place last November 2014.

Sirona continuous to grow in 2015 in the MEA region, what next?

Sirona trusted and will always trust the MEA region as one of our stable markets especially the GCC & Sandi. As we had since 8 years our scientific and training facility in DHCC, Dubai. We are in the process of opening a Sirona UAE office as part of our support to the GCC region, the office will be a Sirona Direct sales & service company and we hope that this will be completed by February 2015. This will be the first direct sales office for Sirona in the region which indicates how important this region for us.

2015 will also be an IDS year, is it possible to see even more novelties from Sirona?

IDS is usually the Dental Mundial where all dentists & dental companies gather, so for sure Sirona will be as always an important player in IDS with new products and innovations. More details about the new products will be shown on Sirona Booth!

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From the royal city of Versailles, Dubai’s exclusive first class dental clinic - Versailles Dental Clinic

By Dental Tribune MCA

A s one of the most successful and recognized Doctor of dentistry in France, what made you decide to expand your dental business in Dubai?

I am originally from Versailles, the royal city of France. I had opened several dental clinics since 1987 they were very successful I think due to the fact that I am a passionate dentist ready to serve my patients with the best technologies, competences and respect. Dubai is a destination I know quite well as I was visiting UAE for more than 20 years for holidays, the idea to move here it looked to me as a new professional challenge.

Dr. Caron, you already succeeded in your career in France being an innovator of dental practice, as you move forward to UAE how do you envision yourself in the market?

Versailles Dental Clinic was established here in 2007, we have had very successful records so far with patients travelling from all over the world for their dental treatments. Thanks to that demand, I have developed a unique approach of full mouth reconstructions, smile makeover in short time span, to suit our travelling patients. I call it “ONE SESSION DENTAL SOLUTIONS”, “reconstruction of a full tooth in one appointment only.

We have patients from Russia, Kazakhstan, Uzbekistan, New Zealand, U.K and Qatar to name a few.

Versailles Dental Clinic is becoming the international indispensable hub for patients seeking the highest quality of dental treatments in the shortest possible time, painless, cosmetic and efficient.

With the fast growing economy of Dubai, competition is arising everywhere aiming to be the best of the best dental institution in the country, what makes you surpass all your competitors and be one of the most prestigious dental institution in the country?

The unique “One Session Dental Solutions” (OSSDS VERSAILLES LABEL) approach, allows me to do treatments such as Root Canal Treatment, Core Build Up and Crown in one visit only, compared to 5-4 visits in other clinics.

Besides that, here at Versailles Dental Clinic, we are really from Versailles from France, and genuine French doctors, National French board certified and really experienced. Our patients trust is a huge value for us.

Another thing to point out in that we are never compromising with quality; our treatments are offering the maximum of safety and guarantee to our patients.

My family and I are based in Dubai, Versailles Dental Clinic has an emergency personalized service in Dubai, basically our patients can reach us any time.

We pay great attention to patient service and we always try to speak in patient’s language. Our Russian/French speaking patient manager will assist the patient from the first visit, to the dental room to the follow-up appointments.

Our patients are fully informed during their consultation; we use the intraoral camera that allows us to show each tooth on a computer screen, it is very beneficial for the practitioner, to be able to provide the most accurate diagnosis and for the patient that can see along the way what exactly his concerns are. We are happy to increase the awareness of our patients about prevention and treatments, and all their questions are always welcomed and answered with transparency.

For more than 27 years in the dental service, starting from Versailles - France and now to Dubai, UAE as a pioneer, developer and innovator of a new and improved dental practice and service, what should we look forward for VERSAILLES DENTAL CLINIC DUBAI?

Seamless, painless, shorts and efficient treatments done in one appointment only with 100% patient satisfaction.

What do we expect from a VERSAILLES dental clinic service? Do you have special or new dental service you want to introduce to the market in UAE?

You should expect the patient satisfaction with the greatest smile from Versailles dental clinic! We are introducing the most efficient and fast communication tool system, “Versaillesdentapad”, which is a new app that allows the patient to see how his smile will look like at the end of the treatment. From the concept of the treatment to its realization and finally with the result. It is a product designed in France and launched just a few weeks ago.

What dental treatment or service can you offer to our tourist reader as well, for fast and effective dental treatment/service?

Broken tooth, tooth ache, cosmetic issue? And of course a flight to catch or a meeting impossible to miss.

ONE SESSION DENTAL SOLUTIONS, as explained earlier, is the right solution in case of any needs of a full dental treatment in one immediate appointment only.

Our call center is used to busy schedules of business and leisure travelers and can find the best booking to provide the needed services in a record time.

As a first class dental service provider in Dubai, how do you maintain your standards and services in providing your clients a well-satisfied and efficient service?

We do not have clients, but patients. As leading dental clinic in the Gulf Region, we are working with high European standards of sterilization, same as in our clinics in France. We receive yearly awards as highest quality dental clinic at all levels. Always focus on infection control management, all our staff is constantly assessed and trained in all the different aspects of oral hygiene. We only work with highly qualified staff and test them on random basis to ensure the consistency of the quality of their daily tasks and service.

About the Author

Dr. Dominique Caron was born in France and studied Dentistry at the University Paris. He founded the first Versailles Dental Clinic in 1987 in Versailles, France. He received the prestigious Médaille of Paris in recognition for his work in new dental techniques and adherence to the dental code of ethics. He is also the former General Secretary of the French Academy of Dental Surgery located in Paris. Dr. Caron established Versailles Dental Clinic Dubai in 2007 in Dubai Health Care City.

Versailles Dental Clinic’s vision is to be globally acknowledged as the leading center for advanced dentistry in the 21st century. Dr. Caron is the Chairman for the Middle East Head Office of The Pierre Fauchard Academy.

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Perfect White leads the way for high stain removal and low abrasion whitening toothpastes

By Chris Dodd

Chris Dodd, Managing Director of Purity Laboratories, discusses the attributes of a safe whitening toothpaste.

As dental professionals, you recognise the importance of your patients avoiding highly abrasive whitening toothpastes as they can damage their teeth and gums, removing the lustre of the teeth and dulling a beautiful smile. By recommending a low abrasion whitening toothpaste, you can ensure your patients protect their tooth enamel while striving to achieve and then maintain their white smile for longer.

It is a well-known fact that the abrasiveness of toothpaste is measured according to the RDA (Relative Dentin Abrasivity) value, and any value over 100 is considered to be "abrasive", something which is unfortunately often not included in marketing or promotional information supplied with toothpaste products, thus masking a common problem.

Interestingly, a USA-based independent testing laboratory (July 2012) tested the abrasion levels of 15 toothpastes. The results confirmed that Beverly Hills Formula's whitening toothpaste is less abrasive than other leading brands of both whitening and regular toothpastes. In fact, Beverly Hills Formula Perfect White scored as low as 95 on the Abrasivity Index Table, whilst some leading competitors displayed levels as high as 130.

To support these abrasion results, an invitro laboratory study found that Beverly Hills Formula whitening toothpastes remove stains in just one minute. Beverly Hills Formula Perfect White (coded as “PLMO/1x1158 Stain Removal” in the study) toothpaste proved effective at removing stains with almost 91% of stains removed over a five-minute period. Meanwhile, other leading brands of whitening toothpastes and toothpolishes scored as low as 41%, a remarkably low percentage, considering water alone removes 48% of staining (2).

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Contact Information
Purity Laboratories Ltd.
Beverly Hills Formula
www.beverlyhillsformula.com

CLINICAL 17

Ranked percentage stain removal following 5 minutes treatment

Ranked percentage stain removal following 5 minutes treatment

RDA Certificate 2012
The Hall Technique: The novel method in restoring the carious primary molar that is challenging old concepts. A new tool in the general dentist’s toolbox?

By Dr. Iyad Hussein

Introduction

Primary molar dental caries in childhood is a disease of epidemic proportions that affects all modern societies. Despite a World Health Organization (WHO) pledge in 1981 to render 50% of 5-6 year old children caries free by 2000 (1), many developing countries remained off target to date. In the UAE, a survey showed that less than 18% of 5 year old children were caries-free (2). In comparison, 45% of 6 year-old and 68% of 3 year-old children in Sweden were noted to be caries-free (3, 4) and recent surveys in England showed that 88% of 5 year olds were free from obvious caries (5). The size of decay as a problem in a society is often expressed as “dmft” (decayed, missing & filled teeth) and is well established as the key measure of caries experience in dental epidemiology. The UAE regions dmft index ranged from 3.8 in Ajman to 6.6 in Dubai (2).

whilst the England dmft figure average was a mere 0.48 (3). This highlights countries/social inequalities where primary dental caries is concerned.

Conventional management of the carious primary molar

Primary tooth decay management represents a challenge for those who dentally care for children, whether they are general dental practitioners (GDPs) or specialists in paediatric dentistry. For the past 5 decades, the dental literature in the USA and Europe had advocated treating the deep carious primary molar in using the conventional “drill and fill” philosophy. That is, give local anaesthesia (LA) to the child by injection to anaesthetise the tooth, drill the carious tissue out (often after placing a rubber dam—Figure 1) using a high and slow speed drill (Figure 2), debridement of the lesion’s bacterial plaque ultimately leading to the arrest of the lesion’s bacterial plaque utilising the “biological approach” which is embodied by the “Hall technique” (8-10).

The Hall technique: “Sealing in” the caries

In 2007, a new technique took the paediatric dentistry world by storm. It recommended a simple way in managing early enamel and dentinal decay in the primary molar using a SSC; it was named the Hall technique (8). This technique involved no local anaesthesia, no rubber dam, no drilling and took place in a child friendly play manner. In essence there was no dental caries removal at all from the carious lesion. The technique relied on sealing the carious lesion in situ cutting off its supply of sugary substrate, thus altering the lesion’s bacterial plaque ultimately leading to the arrest of the caries process in the tooth. The Hall technique involves the

> Page 19
is stuck to the operator’s finger, but not completely through.

with gentle pressure applied to on the tooth to assure that it fits correctly. All SSC, it is tried passively rect SSC in terms of tooth number.

Appointment 2: need for crown preparation (see Figure 5).

Figure 4a & b): The Hall technique: Case selection: 1) Case selection: Diagnosing asymptomatic early enamel and dentine caries in a primary molar, clinically and radiographically (using bitewings). Bitewings may typically show approximal lesions that are not visible clinically but are diagnosed radiographically (Figures 4 a & b). There should be a clear radiolucency between the carious lesion and pulp of the tooth intended to be restored with a SSC Hall technique. There should be no signs or symptoms of pulpal pathosis; the lesion should be detected prior to the development of symptoms (See Table 1).

2) Fitting orthodontic separators: Placement of two elastic orthodontic separators mesially and distally on tooth intended for restoration with a SSC Hall technique (see Figure 5).

B - Hall Technique: Appointment 2: 1) Removal of separators: After 5-3 days the patient returns for the removal of the orthodontic separators. Space is created mesially and distally that will negate the need for crown preparation (see Figure 6).

2) Stainless steel crown selection and placement: The patient is sat up in the supine position and the operator selects the correct SSC in terms of tooth number and size. After selecting the correct SSC, it is tried passively on the tooth to assure that it fits with gentle pressure applied to the SSC over the contact points but not completely through. For safety purposes the crown is stuck to the operator’s finger, while trying out the size, using an adhesive tape/elastoplast. The SSC should not be too loose or too tight. The crown should “spring back” from the contact points while trying it on the tooth at this stage. After crown selection, the crown should then be filled with a self curing glass ionomer cement and positioned over and on the tooth. The operator then digitally presses the crown through the contact points so that the crown flexibly “clicks” on the tooth and fits snugly. The patient is then asked to bite on a cotton wool roll to finish off its correct positioning (see Figure 7). The excess of the glass ionomer cement is wiped off. The crown should be level with the occlusal plane and blanching of the gingiva will be noticed buccally and palatally indicating an adequate seal (see Figure 8). The patient may feel a little tightness, however that and the gingival blanching disappear within an hour or not less (Figure 9). Equated to the tightness of a brand new pair of shoes around feet, it resolves spontaneously after a while. Occasionally the bite may be raised by a milimetre, however dento-alveolar swelling and radiographically for signs of interradicular radio- lucency or root resorption.

Discussion The Hall technique was named after Dr. Norma Hall, a Scottish dentist who worked as a salaried GDP in a remote high dental caries risk area (Scottish West- ern Isles) north west of the UK. As she faced a high proportion of children with dental caries (dft of Scotland was around 2.54 at the time), and was not a specialist in paediatric dentistry, she thought “outside the box” and used SSCs to “seal in” dental caries with no preparation and no anaesthesia or drilling (see Figure 10). This technique caught the attention of the team of paediatric dentists/clinical researchers at Dundee Dental School in Scotland (11). They took an interest in Dr. Hall’s novel work (she had audited her own work) as they were facing very high levels of dental caries themselves. Subsequently a pilot trial by Evans et al was published online in 2000 (11). This prospective controlled study assessed 49 patients who were fitted with SSC crowns using the Hall technique from the patient, caregiver and dentist point of view. It was deemed a success as the study reported very high levels of satisfaction. In addition, the team of Dundee Dental School researchers shared their findings with The British Society of Paediatric Dentistry UK national conference meeting in Edinburgh (UK) in the same year (2000) to the astonishment of its audience (the author of this paper was present that day and recalls the reaction). Because the initial reaction to this technique by other paediatric dentists in the UK was profound (12), the team of Dundee University researchers (Innes et al) undertook it upon themselves to investigate this technique by employing the most robust methods of evidence-based dentistry; namely a prospective randomized controlled clinical trial and first published their results in 2007 (8). This study formed the pivotal event that made this technique a “school of thought” in paediatric dentistry by its own right. Because of its importance in this study, it will be discussed further below.

The 2007 study (8) was a prospective split mouth randomized control study that recruited 152 child patients aged between 5-10 all of whom had two matched dental carious lesions. Each child acted as his/her own control. The two lesions each child had were similar to the lesions highlighted in the example given above (Figure 4a); there were no clinical or radiographic signs of pulpal pathosis. One lesion was randomly treated using the Hall technique and the other was randomly treated conventionally (mostly by glass ionomer cements). Seventeen GDPs treated these patients under the auspices of the paediatric dentistry team at Dundee University.

Can You See Who’s Wearing Braces? (Your patients can’t see them either)
Dental Tribune Middle East & Africa Edition | February 2015

The results were an outstanding success rate of 98% for the Hall SSCs when compared to the control restorations (5%) in terms of major failures, pain due to pulpal symptoms, and the authors concluded that “The Hall Technique was preferred to conventional resto-
ration by both patients and parents.”

There was a mixed international reaction to the development of the Hall technique. For example, clinical researchers in Europe reported that the technique resulted in satisfactory outcomes for pulpal health and restoration longevity compared to conventional restorations. The wide gulf. Letter to the BDJ, 2014; 12: Roberts, RF and Attari N.

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13) Santamaria RM, Innes NPT, Machiulskiene V, Evans DJP and Siprih Ch. Caries Man-
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14) Santamaria RM, Innes NPT, Machiulskiene V, Evans DJP and Siprih Ch. Acceptability of different caries management methods for primary molars in aRCT, (Accepted for publication in the International Journal Pae-

15) The Magazine of the Ameri-
can Academy of Pediatric Den-

The Hall Technique: Figure (11a) shows an OPG radiograph taken at follow up for the same patient seen in Figure 10. There were no clinical or radiographic signs or symptoms of pulpal pathosis. Figure (11b) shows the 4-year follow up of SSC using the Hall technique. It shows adequate coverage of the primary molar.

Table 1. Indications and contraindications of the Hall technique.

<table>
<thead>
<tr>
<th>Indications</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I lesion, non-cavitated, if patient unable to accept fissure sealant, or conventional restoration.</td>
<td>Cavitated Teeth with signs or symptoms of irreversible periradicular lesion.</td>
</tr>
<tr>
<td>Teeth with carious lesions that could be opened slightly following placement of a Hall SSC, but it corrects itself rapidly in children.</td>
<td>Teeth with clinical or radiographic signs of pulp necrosis.</td>
</tr>
<tr>
<td>Dento-alveolar compensation of at least 1 mm should be assessed before considering for permanent restoration.</td>
<td>Rubber dam, drilling the caries out.</td>
</tr>
<tr>
<td>The crown could be bonded directly to the tooth, i.e. no metal base is necessary.</td>
<td>Bonding of a metal base is necessary.</td>
</tr>
<tr>
<td>The reader is asked to compare Figure 3 (c &amp; d) to Figures 10 (a &amp; b); one patient had multiple injections while the other did not have any for the SSC placements.</td>
<td>The procedure is not suitable for small children in a chair.</td>
</tr>
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<td></td>
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</tbody>
</table>

The Hall technique for restoring the carious primary molar is a newly developed technique that is based on an old concept: the bite resolves itself with props open the bite after placing a Hall SSC, but it corrects itself rapidly in children due to dento-alveolar compensation. This will negate the need for LA injection, rubber dam, drilling the caries out. The reader is asked to compare Figure 3 (c & d) to Figures 10 (a & b); one patient had multiple injections while the other did not have any for the SSC placements. The crown could be bonded directly to the tooth, i.e. no metal base is necessary. The reader is asked to compare Figure 3 (c & d) to Figures 10 (a & b); one patient had multiple injections while the other did not have any for the SSC placements. The crown could be bonded directly to the tooth, i.e. no metal base is necessary. The reader is asked to compare Figure 3 (c & d) to Figures 10 (a & b); one patient had multiple injections while the other did not have any for the SSC placements.
Dental Tribune Middle East & Africa Edition | February 2015

3rd Qatar Dental International Conference
11 – 12 December 2014, Doha, Qatar

By Dental Tribune MEA

Doha, Qatar: Dental Tribune MEA visited the 3rd Qatar Dental International Conference on 11 – 12 December 2014. We find out more from the President of Qatar Dental Association – Dr. Mohammed Al-Darwish on the developments in Qatar.

Dental Tribune MEA: How do you reflect back the time since Qatar Dental Society was established in 1992?

Dr. Mohammed Sultan Al-Darwish: Before 2006, we dreamed to have an organization covering all dentists in Qatar under one umbrella. We dreamed to have a dental conference in the country. We dreamed to have a dental society similar to our neighboring countries. Therefore, a group of 20 dentists held a small meeting and after a 5 hours discussion on all of the challenges, the decision was to establish a dental society in the country. Now, after 6 years we reach some of the targets we had set ourselves.

As President of the Qatar Dental Society, how have you seen dentistry develop in Qatar during your current term as leader of the QDS?

When I started my term as the first president of Qatar Dental Society, the number of dentists in Qatar were 657. Now in 2014 we reached 1228 dentists. We organized the first, second and third Qatar International Dental Conference. Also, more than 12 small exhibition areas (8 booths). The conference has grown over the years and the scientific program included 26 lectures with 8 workshops. The exhibition area consisted of 20 booths. More than 12 Deans of dental schools attended this conference. As I mentioned during the opening ceremony of this conference, the supreme council of health in Qatar decided that a dentist must have 40 CME each year to renew the license and 15 CME out of 40 must be local. At this point we are looking forward to make the conference annually.

Are there plans for a Dental University to open up in Qatar any time soon?

Yes, there is a plan to open a dental school in Qatar, and now we are in the preparatory stages of making this happen.

Dr. Mohammed Sultan Al-Darwish distributing the trophies

What advice do you have for the young generation of dentists in Qatar?

Work hard, continue your study with an advanced program and master degree, involve yourself in dental researches and do not forget to attend dental conferences and workshops to keep yourself updated with the new dental technology.

Is there anything else you would like to share with the readers?

Qatar Dental Society would like to thank Dental Tribune MEA/ CAPP for participating in the 3rd Qatar Dental International Conference.

Contact Information

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SEM images of denture surface.
*In vitro single species biofilm after 5 minutes soak.
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Ref: CH-SA/CH-IPLD/0008/14c
Modern implants from a different angle

By Safa Tahmasebi BDS, MS (US) Prosthodontist, Costa Nicolopoulos BDS, FFD (SA) Oral & Maxillofacial Surgeon

Background
With the success of dental implants, the profession of dentistry has moved into applying innovative ideas that have decreased treatment time and amplified the quality of patient’s lives. While integrating into modern dentistry, implant treatment has shifted direction from being surgically driven to prosthetically driven. Amongst other developments in improving all aspects of implant dentistry, angled implants were first introduced in the early 1990’s and since then there has been ample research to conduct studies to assess and support their success. (Figure 1)

Implants were originally tilted in a bodily fashion to bypass certain anatomical constraints that otherwise hindered clinicians from placing them in areas such as the maxillary sinus, inferior alveolar nerve canal, the mental foramen, mandibular lingual concavities and maxillary buccal concavities. Procedures such as nerve repositioning, various grafting procedures, distraction osteogenesis, ridge splitting and many more not only lengthened treatment time, but also increased patient morbidity during implant rehabilitation cases. In addition to bypassing the anatomical constraints, the ti lling of posterior implants in a distal manner results in an increase in the length of the prosthetic table thereby allowing better load distribution and, reducing the cantilever effects. With time, tilted implants became an effective and safe alternative to major augmentation procedures such as maxillary sinus grafting procedures and ridge augmentation procedures.

Initially there were negative speculations regarding the hard and soft tissue response around tilted implants as opposed to axially straight implants. However various in vitro and in vivo studies have proven no apparent long-term detrimental effects associated with tilted and straight implants. Kerekanos et al in 2000 followed up forty-seven consecutive patients with tilted implants for forty months and showed no significant difference between tilted and non-tilted implants. A comparative 3D finite element stress analysis conducted by Cases et al in 2008 showed no indication that angled implants create stress-induced problems compared to straight implants. A meta-analysis preformed by Misch et al in 2012 evaluated the outcomes of upright and tilted implants supporting full arch dentures in immediate rehabilitations of edentulous maxillae, after at least 1 year of function. No significant mean difference between tilted and upright implants was found with regards to bone loss. Rosén et al in 2015 retrospectively evaluated the surgical effect of tilting implants in the severely resorbed edentulous maxilla as opposed to bone grafting and conditioned soft tissues to restore the posterior maxilla. In a ten-year study patients with tilted implants showed significant improvement in the demaning grafting techniques.

Angled abutments
Furthermore while angled implants improved load distribution, reduced augmentation procedures, lessened cost, treatment time and eliminated cantilever effects in many cases they did necessitate the use of angled abutments to achieve a parallel path for the draw of the final prosthetic. Custom or prefabricated abutments were necessary to redirect the screw access holes in a common path of insertion to aid in the fabrication and installation of the final prostheses. In addition these abutments were also used to redirect the screw access hole in the lingual direction to aid with esthetics of the final restoration. In cases of severe angulation abutment placement to limited is the use of cemented restorations with the use of custom made abutments. (Figure 2)

Although these abutments are widely used today, they do present certain disadvantages that warrant mention. Firstly the connecting surfaces of custom made abutments may have a casting imperfection that may attract bacteria and bio film accumulation. Secondly if used in cemented restorations, they promote the use of cements that can cause untreatable peri-implantitis and peri-implant mucositis. Thirdly, missing of the custom abutment decreases the abutment’s firmness of the gingival position and hence the screw axis hole within the surgical guide may be used to orientate and assess the 3-D position of the desired direction indicators that may be used to orientate and assess the 5-D position of the desired access hole within the surgical guide(Figure 6). The angled direction indicator is inserted into the osteotomy and the prosthetic axis is checked regarding the access hole position for screw retention as well as for parallelism with other implant fixtures. When the orientation is con-
firmed, then the site is enlarged to appropriate implant diameter & length and the implant with the appropriate built in angulation is inserted(Figure7). The angle correction of the implant is therefore at a sub-crestal level and prosthetic space is not utilized by angulated abutments.

Conclusion

Today more clinicians are advocating the use of angled implants. This leads to less grafting procedures that not only minimizes the overall treatment time, but also reduces the cost and diminishes the patient’s morbidity associated with grafting procedures. Co-Axis implants also allow early or immediate loading protocols that would otherwise not be possible with conventional implants. Therefore, the use of native bone, the avoidance of expensive angulated abutments, decreased patient morbidity, reduced cost, benefits of immediate loading, likelihood of screw retained restorations, and elimination of long cantilevers are all advantages of using Co-Axis implants.

References

8. Costa Nicolaoupolos DDS, FFD (SA) MFOS Oral & Maxillofacial Surgeon Dr. Costas BDS qualified as a dentist in 1991 receiving his dental degree cum laude from the University of Witwatersrand, Johannesburg, South Africa. He graduated top of his class with rank order No.1 and received numerous awards including the Gold Medal of the Dental Association of South Africa for the most outstanding graduate. In 1996 he completed his 4 year full time postgraduate Maxillo-Facial & Oral Surgery training at University of Witwatersrand, South Africa and was awarded FFD (SA) MFOS.Since 1991 he is in full time specialist Maxillo-Facial & Oral Surgery practice concentrating on immediate loading of dental implants. To date he has placed over 50,000 dental implants. He has also presented as a key lecturer at numerous international implant congresses.
9. SameDay Dental Implants Unit 107, Building 59, DHCC Dubai, UAE. PO Box 505190, Dubai, UAE.
Email: costa@samedayme.com Safa@samedayme.com

Figure 6. 12° direction indicator within a surgical guide
Figure 7. Direction indicators left to right (0°, 12°, 24° and 36°)
Figure 8. The use of 12°, 24° and 36° implants in a fixed maxillary immediate loading rehabilitation

About the Authors

Dr. Safa Tahmasebi D.D.S, M.S Cert. Prosthodontist (USA) Dr. Safa Tahmasebi Completed his Bachelor’s degree in Biology and a minor in Biochemistry at Saint John’s University Queens New York in 2004 with a full scholarship based on academic performance. In 2005 he joined State University of New York at Buffalo School of Dental Medicine where he attained his Doctor of Dental Surgery and qualified as a Dentist in 2008. He joined the Albert Einstein Medical Hospital of Montefiore in Bronx New York where he completed one-year hospital dentistry fellowship. In 2013 he completed three and half year full time training in prosthodontics and surgical training with a masters degree in prosthodontics at the West Virginia University School of dentistry. During this time He was an adjunct clinical instructor to the undergraduate programs at the WVU University. In 2015 he joined the SameDay Dental implants Bränemark Osseointegration Center (BDC) Dubai as a full time prosthodontist specializing in full mouth rehabilitation, immediate loading and Smile reconstruction.
Sinus lift with simultaneous implant placement

Piezosurgery offers the patient a gentle treatment with less complications and time saving benefits.

By Dr. Peter Hentschel

Oral rehabilitation has been paid notice for a long time to regain masticatory function and for aesthetic reasons. Implant placement in the maxilla is often limited due to missing height of the alveolar process, this can be solved by external Sinus Graft (Boyne 1980). The alveolar crest can be built up to 8-15 mm by Sinus Eleva.

The alveolar crest can be built up to 8-15 mm by Sinus Eleva. The function of the sinus is not touched by the reduced volume. The success rate is between 85 to 96 % after 15 years. The functional pressure non-resorbable bone substitute material (eg. CompactBone B, bovine Bone) can be avoided by simultaneous augmentation a second surgical procedure within piezoe-surgical window preparation and drilling process (Fig. 1).

At external elevation and sinus augmentation a second surgical process, this can be solved by external Sinus Graft (Boyne 1980).

For filling of horizontal-cranial space and stabilization of bone lid a bovine bone graft is used (Fig. 11). Autologous bone was gained during drilling process (Fig. 1).

Grafted Bone Regeneration (GBR) as state of the art method for bone grafting uses in most cases bioresorbable Membranes. Resorbable membranes offer several advantages beside the easy handling, as no need for a second surgical procedure for removal or minimization of complications, e.g. soft-tissue dehiscences.

The during the procedure gained autologous bone can be placed alone or in combination with a bone graft material (eg. Compact Bone S, biphasic Calciumphosphate) around the placed implant. Sinus Elevation with simultaneous implant placement is indicated with up to 97.9% survival rate in after years (Pfeleg et al. 2000).

Guided Bone Regeneration (GBR) as state of the art method for bone grafting uses in most cases bioresorbable Membranes. Resorbable membranes offer several advantages beside the easy handling, as no need for a second surgical procedure for removal or minimization of complications, e.g. soft-tissue dehiscences.

After release of the sinus membrane (Fig. 4) the implant tunnel was prepared (Fig. 5) and the Implant (SL Implant; Dentegris, Germany) placed (Fig. 6). Simultaneously the surrounded space was covered with a rehydrated Collagen Membrane (Bone Protect Membrane; Dentegris, Germany) as protections of the Schneiderian membrane (Fig. 7). Autologous bone was mixed with Compact Bone B and placed in the sinus for stabilization (Fig. 8).

For filling of horizontal-cranial space and stabilization of bone lid a bovine bone graft is used (Compact Bone B; Dentegris, Germany). Bovine bone has been used in dental surgery for decades and is well known for stable and reliable results.

To ensure the barrier and to stabilize the particulated bone grafting material a pericardium membrane with a resorption time of 16-24 weeks is used (Bone Protect Membrane; Dentegris, Germany). The pericardium membrane offers very good handling properties in combination with a prolonged barrier function.

Case Study

The patient (30 y, f) was showing an alveo loco lost tooth in 15 (Fig. 2). Patient request was aesthetic and masticatory rehabilitation which was suggested by one- stage internal Sinus Lift. Based on diagnostic planning piezosurgical window preparation in 15 (Fig. 3) was performed after local anesthesia and periostal flap. By choosing a round-oval lid design sharp edges can be avoided which reduces the risk of perforation.

After release of the sinus membrane (Fig. 4) the implant tunnel was prepared (Fig. 5) and the Implant (SL Implant; Dentegris, Germany) placed (Fig. 6). Simultaneously the surrounded space was covered with a rehydrated Collagen Membrane (Bone Protect Membrane; Dentegris, Germany) as protections of the Schneiderian membrane (Fig. 7). Autologous bone was mixed with Compact Bone B and placed in the sinus for stabilization (Fig. 8).

After control of primary stability particulate materials was filled laterally and covered with pericard membrane according to GBR standards (Fig.9). The flap was readapted and closed, control by X-ray shows axial positioning and augmentation of sinus maxillaris (Fig. 10).

Reentry after five months was accompanied by full ceramic crown and results in aesthetic and harmonic rehabilitation (Fig. 11).
RITTER IMPLANTS SYSTEM

By Ritter Implants

Founded in 1887 by the German Frank Ritter in New York, Ritter is one of the oldest prestige brands of finest dental equipment worldwide. Due to innovative ideas and a great entrepreneurial spirit, Ritter produced the first dental units already more than 125 years ago.

Today Ritter products are more than ever an essential element in dental practices worldwide. Users appreciate the Ritter product range for the high-quality aspects and the reliability - Made in Germany. Due to their functionality and user orientated construction, Ritter dental units contribute constantly to an optimized workflow of today’s modern dental practices.

In the course of the last years, Ritter has started to write a new success story with the launch of an innovative, state of the art implant system. The Ritter Implant Ivory Line provides Two Piece Implants (Implant plus separate Abutment) as the QSI Spiral Implant and TFI Twin Fissure Implant as well as One Piece Implants (Implant and Abutment already connected) called Mono Compress Implant MCI. The system contains logically reduced and clearly arranged components of tools and abutments with the best features for all clinical cases. Due to the super Nano-Surface, a quick and reliable Osseo-Integration is guaranteed. Clever and easy handling is provided by self-tapping threads and a coloured system of drills and implants according to their diameters.

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As President of ANDI Rome I must attribute this success to a great team work with the same purpose and to an incisive efficiency which make me proud and very satisfied. The involvement of ANDI Lazio, ANDI Naples and ANDI Campania underlines and highlights a desire of unity, collaboration, foresight which will be able to positively affect the future work of everybody in order to promote the “excellence” in the world of dentistry.

On June 18-19-20, 2015 a big event on a scientific debate will be celebrated in Rome between the Mediterranean and Middle East countries and we hope it will become the starting point for a collaboration for a better future for all of us.

I wish you a great job and see you in Rome!

Sabrina Santaniello
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Gabriele Edoardo Pecora
With great satisfaction we announce the participation of numerous lecturers coming from many worldwide countries and the city of Rome will be a meeting point for networking and sharing, a new project which looks at the future of the dental world.

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For more than 125 years, Ritter provides high quality products – Made in Germany

By Dental Tribune MEA

Dub, UAE: Ritter Concepts, one of the oldest brands of dental chairs worldwide is expanding in the region. Christian Findeisen, Export Sales Manager Middle East & Africa at Ritter Concept GmbH elaborates on the region.

Dental Tribune MEA: Christian, during the last 6th Dental Facial Cosmetic int’l Conference in Dubai we witnessed a new impulse with Ritter. What is the reason for the new fresh look in the MEA region?

Mr. Christian Findeisen: Indeed a lot of changes and new movements have happened within Ritter in the last months. First and foremost Ritter acquired the dental manufacturer EGNER, also based in Germany. This acquisition will strengthen our position in the international dental market and bring innovative impulses into our structure. The EGNER Dental Manufacturer (formerly known as GIRARDELLI) has been well known and established in the dental market for decades. Originally known for the production of its x-ray film processors, EGNER expanded the product portfolio by newly developed dental treatment units. This merger initiated the process for a new and common orientation in all segments. Consequently we are merging the company philosophies, sales strategies, product ranges and market- ing approach. We intend to combine the long term experience of both companies with a young and fresh approach. The final concept, which will also include product developments and news, will be presented in the early stages of next year.

What is the main strength of Ritter and what can you offer to current and potential customers?

Ritter is one of the oldest prestige brands of dental chairs worldwide. For more than 125 years Ritter provides high quality products – Made in Germany, for modern dentistry with great innovative aspects. Users worldwide benefit from Ritter’s large experience and reliability. Our products enjoy the reputation of being extraordinary solid, long-living and extremely easy in maintenance and service. Moreover Ritter is one of the last owner-managed companies. This enables us to be more flexible than most of our competitors and to offer individual service and product solutions for our customers.

How do you plan to expand your presence in the MEA region for the coming years?

2014 was an important year for Ritter in the Middle Eastern countries. Personally I started developing the market at the beginning of the year. In June we started our exclusive partnership with Henry Schein, which opened up wide opportunities and a wide network of sales and distribution channels for Ritter. With this strong partner at our side we intend to develop the Middle Eastern countries further and become step by step the main brand for dental chairs and devices in this region. This will certainly also include the enlargement of our Ritter Sales and Service Team within the next years.

How has the partnership with Henry Schein and your new distributor Schein Technologies effected Ritter for the region?

Having started our exclusive partnership with Henry Schein in the course of 2014, we have great plans for the coming years. We are delighted to set up our latest sales and service approach with such a strong and internationally experienced partner like Henry Schein. Our common aim is to provide high-quality dental equipment – made in Germany – at an interesting price-performance-ratio, performed with personal consultancy and comprehensive local services. We believe, that the mix of local background and knowledge of two global companies will be the gateway to success. Henry Schein Middle East LLC is based in Dubai directly. All customer requests can be handled locally, in a quick and flexible way. The technical engineers are specialized in the installation and service of dental equipment. Moreover Henry Schein provides a strong network of dedicated Henry Schein distributors in each country. The experienced Ritter Export Managers support all activities continuously. The customers receive a full-service spectrum of care. We already realized a great launch event in Dubai and a wide range of activities and will spread these out widely. Also the upcoming AEEDC in Dubai represents a good opportunity to show our common strengths. We strongly believe that this partnership will create a wide range of synergies and services from which our clients will benefit.

With IDS Cologne coming up, can we expect some novelties from Ritter?

Of course we will present novelties in the fields of dental units, x-ray devices and compressors/auction. We are more than proud to show our new and modern dental unit ARIA SR with outstanding design opportunities and convincing qualitative aspects for every user. More detailed information about the new products will follow as soon as possible. And the charming thing is, that we will already present them for the first time at the AEEDC in Dubai in February. This means, that the Middle Eastern countries will be one step ahead.

What do you expect from Dental Tribune as your Media partner for the coming years?

We are very excited with the platform Dental Tribune MEA offers to Ritter and Henry Schein. Our expectation is that together we will be able to satisfy the needs of the dental professionals in the Ritter Concept GmbH Mobile No: +971 – 56 9578689 Mr. Christian Findeisen christian.findeisen@ritterconcept.com www.ritterconcept.com

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By Dental Tribune MEA

Dr. Ghassan: I joined the Henry Schein team in October 2010 and immediately we established the Henry Schein private label and exclusive brands (the companies to supply the end users with the full requirement from A to Z whilst improving our dealer services and delivery to reach customers with maximum satisfaction.

Can you elaborate on Henry Schein Middle East and your portfolio as a company?

Henry Schein Middle East covers now all the requirements for the end user in dentistry through the following lines:
- General consumables, dental materials and instruments (Henry Schein private label line including over 8000 products - www.henryschein.com)
- Lab materials (Zahn Dental and Pentron Ceramics - www.zahndental.com)
- Handpieces and small equipment (BA International - www.bi-international.co.uk)
- General spare parts and services (Handpiece Headquarters - www.handpieceheadquarters.com)
- Dental Units, general equipment and Furniture (Biter Concept - www齿器概念.com)
- CAD/CAM systems: o Clinical: PlanScan, PlanMill and X-Ray Cone Beam systems (Planmeca - www.planmec.com)
- Dental laser and specialized material (CAO group - www.caogroup.com)
- Endodontics and Surgery and Implantology
- Orthodontics
- Endodontics - CAD/CAM Technologies

What is the impression of the level of dentistry in the MEA region?

The level of dentistry in the region is growing very fast in all divisions and branches. This area is considered to be an entry point for other regions in the world and this is the main reason why Henry Schein puts wide attention and investment to support and service dentistry in the MEA region.

What impact has digital dentistry had in the MEA region?

Digital dentistry becomes a vital topic in the Middle East market and Henry Schein places it as a high priority in our profile. With this being said, Henry Schein has launched the only open complete CAD/CAM clinical and Lab system in the market from Planmeca and Zahn Dental with Zirxus complete CAD/CAM consumable solutions along with the dental management software from SOE and the cone beam system from Planmeca.

How important is Education for Henry Schein Middle East and what are your plans for the coming year?

Henry Schein is considered a leading company in the education line along with supplying most of the universities around the world with the basic and high scientific required materials and equipment. We are preparing a full education program to cover the following subjects: -Cosmetics and Prosthodontics -Orthodontics -Surgery and Implantology -Endodontics -CAD/CAM Technologies

With a certified degree supported by a well-known University in the scientific field, we are planning to announce the details of this launch during the upcoming AEDDC 2015 for the first time.

2014 was a strong year for Henry Schein and you have added new companies to your portfolio such as Planmeca and Ritter, can you explain the partnership?

The Henry Schein plan and strategy in Middle East is to cover all the requirements for the end users with the best scientific and economic solutions. This is why we keep adding to our profile the top companies to be able to serve the end user. We signed an exclusive distribution agreement in the Middle East with Ritter concepts (for their dental units and equipment) and with Air Techniques (for their air compressor and suction phosphoric plates scanners) as well as with Planmeca for their CAD/CAM clinical system and Cone Beam which we are very proud of. We are planning to add more companies in the coming years.

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Beverly Hills Formula

Figure 1: 2D periapical radiograph of previous RCT on tooth #3

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INDUSTRY 31

Dental Tribune Middle East & Africa Edition | February 2015

CS 8100 3D Extraoral Imaging System CBCT provides clarity of prognosis

By Mark Anthony Limosani, D.M.D., M.S., F.R.C.D

Case Overview
A 67-year-old female taking Forteo (Teriparatide) for the treatment of osteoporosis was referred to my office by her general dentist because of her history of ongoing low grade discomfort associated with the UR quadrant and more specifically tooth #5. Her dental history revealed previous root canal therapy was completed on tooth #5. She didn’t recall when, but was confident it was greater than five years prior to presenting to my office.

Clinical examination revealed a slight buccal swelling associated with the tissue buccal to tooth #5. No sinus tract was evident. The palpation of the temporals and masseter...
ter muscles did reveal some trigger point sensitivity suggestive of myositis possibly subsequent to parafunctional habits. Tooth #5 demonstrated slight sensitivity to biting, palpation and percussion. A 6mm probing was noted on the mesiobuccal (MB) aspect of the palatal (P) root. This finding was consistent with purulent discharge.

The PA radiograph (Figure 1) demonstrated that tooth #5 had previous root canal treatment. Probable radiolucent findings were associated with the apical portion of the MB and P roots. The root canal filling material associated with all three roots appeared underestimated and under-filled. A decision was made to take a cone beam computed tomography (CBCT) scan in order to obtain more valuable diagnostic information.

Findings

The sagittal slice demonstrated attenuation patterns suggestive of a narrow bony defect associated with the MB aspect of the P root of tooth #3 (red arrows) and furcal defect (blue arrow) on #3 unaddressed MB2 canal (yellow arrow). Figure 3: Axial view with finding of an aspect of the P root of tooth #3 (red arrows) narrow bony defect associated with the MB and palatal roots. The root canal filling material associated with all three roots appeared underestimated and under-filled. A decision was made to take a cone beam computed tomography (CBCT) scan in order to obtain more valuable diagnostic information.

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From design to fabrication in a few minutes

Mrs. Esther Moll, KaVo application technician and dental technician, presents a design made with the ARCTICA-Software package

By Mrs. Esther Moll

The DentalDataBase user interface (Figure 1) shows all individual steps, from order creation, scanning, design to data transfer to the milling machine. To illustrate the rapid and simple realization of a design, the description of the "step-by-step wizard" contains the time code. Tooth 21 is to be supplied with a crown. Design inputs are the current situation (Figure 2) and the mirror tooth 11. The impression of the current situation is taken and the scanned data are stored. The tooth is prepared, the impression is scanned.

02:25 p.m. - Data are stored.

02:26 p.m. - Data of the prepared 21 and the impression of the current situation is uploaded. The crown is positioned on the prepared stump (Figure 5).

02:27 p.m. - The step-by-step wizard leads to the next step of the process. The preparation line is created by the software via "I-click" (Figure 4).

02:28 p.m. - The software shows the calculated restoration shape (stump, Figure 5). This proposal by the software could still be individualized or changed.

02:29 p.m. - Mesial and distal contact points (Figure 6) are set.

02:30 p.m. - The software has positioned the database tooth (Figure 7).

02:30 p.m. - The step-by-step wizard offers to adapt the database tooth (white) to the situation (turquoise). The process step in the box (right) is called "Adaptation of model teeth.

The software calculates the correction (Figure 8).

02:50 p.m. - Adaptation of the design is complete (Figure 9).

02:51 p.m. - This process step (Figure 10) would allow additional changes or corrections. Proceed to the next process step with the "Continue" button.

02:51 p.m. - The system offers to trim the antagonist (purple) (Figure 11). Contact points to the adjacent teeth can be created or reduced.

02:53 p.m. - The MultiCAD software package now calculates the anterior tooth crown, compiles the data and generates the milling data (Figure 12).

From now on the order for milling the crown can be issued. Access the "KaVo Software Suite" through the "DentalDataBase" button in the DentalDataBase. This controls the engine. Use the start menu to select fabrication job and tool magazine and completes the order (Figure 13).

“With a little practice “simple” individual crowns can be done in five minutes”

In the interview below with KaVo’s, dental technician Esther Moll discusses the ARCTICA System’s further possibilities.

By KaVo

Dental technician Esther Moll has been an application technician with KaVo Dental since 1 October 2007 and works with KaVo Everest, KaVo multiCAD and KaVo Arctica. During product pilot phases, she acts as expert contact person for validations, correction of bugs, software tests, etc. In addition, she complained manager and works for international support. On the occasion of her user report, DZW spoke to Esther Moll about the particularities of KaVo’s Arctica System.

Q: Ms Moll, for a crown design to take barely ten minutes as described in the example, is this achievable for absolute Arctica professionals only?

Esther Moll: Anyone who has sufficient knowledge to define a crown by its key anatomic features can do that. With a little practice “simple” individual crowns can be done in five minutes, and this is not done at the expense of high quality or later functionality.

How long does it take to learn to operate a software package such as KaVo-multiCADSoftware and what help does the software package itself offer?

The KaVo multiCAD-Software can claim to be very user-friendly. All basic functions can be learned within a day. This know-how is sufficient to design approx. 80 percent of all day-to-day prosthetics tasks. The software guides its users through all required design steps so that operator error can almost be completely eliminated.

... and which materials can KaVo’s Arctica process? Are materials for temporary works being offered?

All that is possible. The range of materials includes not only but a number of ceramic materials. That includes of course the high performance ceramic zirconium oxide, but also Vita Mark II with its more than 20 years of clinically proven track record in various options including multi-coloured blocks. There is, moreover, the option to process titanium, a material especially attractive for implant restorations and with many possibilities. The program also includes various plastics. Vita CAD-Temp is designated for temporary parts; in addition the glass-filled high performance polymer C-Temp with its bending strength of 500 Megapascals is available for long-term temporary parts. And finally there are C-Cast plastic or easy to mill waxes for use in conventional casting technology.

The design of a single crown takes barely ten minutes. How does the subsequent grinding process take in KaVo’s Arctica-Engine?

At the moment, a single crown is done in approximately 20 minutes – and this despite the five-axis technology, which is capable of fabricating even complex shapes. We are working on process optimizations that could lead to process times of ten minutes.

How much space will I have to allow for an Arctica system in my lab? Is a tabletop sufficient?

Yes, a big advantage is its size - half a technician’s bench is easily sufficient. The Arctica-Engine’s dimensions of 30 1/2 x 25 1/4 x 25 inch (775 x 500 x 584 millimeters) and its installation depth of 20 2/5 inch (524 millimeters) are indeed very compact.

Contact Information

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Figure 1: The DentalDataBase

Figure 2: Initial situation and definition of target situation

Figure 3: Positioning

Figure 4: Intelligent preparation line determination

Figure 5: Calculated restoration shape

Figure 6: Contact point

Figure 7: Software places a database tooth

Figure 8: Correction of database tooth

Figure 9: Adaptation of database tooth

Figure 10: Query for further adaptation requests

Figure 11: Trimming the antagonist

Figure 12: Crown calculated – ready for fabrication

Figure 13: The “KaVo Software Suite”
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By Michael WJ Dodds, BDS, PhD,Wm. Wrigley Jr. Company
Excerpt from paper originally published in the Journal of the Irish Dental Association

The use of sugar-free gum provides a proven anti-caries benefit, but other oral health effects are less clearly elucidated. Oral health, particularly caries-reducing, benefits of sugar-free chewing gums have been well documented in many studies and reviews. In addition, chewing gum is increasingly being viewed as a delivery system for active agents that could potentially provide direct oral care benefits. Chewing sugar-free chewing gum promotes a strong flow of stimulated saliva, which helps provide a number of dental benefits:

• the higher flow rate promotes more rapid oral clearance of sugars;
• the high pH and buffering capacity of the stimulated saliva help neutralise plaque pH after a sugar challenge;
• studies have shown enhanced remineralisation of early caries-like lesions and ultimately prospective clinical trials have shown reduced caries incidence in children chewing sugar-free gum.

Scientific evidence shows that chewing gum has a place as an additional mode of dental disease prevention to be used in conjunction with the more traditional preventive methods.

Benefits of chewing sugar-free gum

Oral clearance and saliva stimulation, plaque pH neutralisation
The major benefits of sugar-free chewing gum are mediated through oral physiology: stimulation of the salivary glands to produce a strong flow of saliva (a 10-12 fold increase over unstimulated saliva) is elicited by a combination of masticatory and gustatory stimuli. Although saliva flow rates are highest during the first five to seven minutes of chewing, when the sweeteners and flavour release is maximal, a two-fold increase in flow rate (over unstimulated flow) is maintained for as long as the gum continues to be chewed.

One of the immediate short-term effects of this enhanced saliva flow is the increased clearance of sugars and food debris from the oral cavity. The higher flow rate, pH and buffer capacity of stimulated saliva helps neutralise acids found in the mouth, and in particular help raise the plaque pH. The short-term neutralisation of plaque pH out of the demineralisation danger zone can also be supplemented by medium-term benefits, as it has been shown that frequent chewing increases baseline (unstimulated) saliva flow rate and increases the resting plaque pH and subsequent ability of the plaque to form acid from sugar. Some studies have suggested that chewing gum is better tolerated than artificial saliva for symptomatic relief of xerostomia.

Remineralisation and clinical caries reductions
In addition to the pH neutralising effect, the increased rate of delivery of soluble calcium and phosphate ions from the stimulated saliva helps to remineralise surface enamel lesions, as shown in a number of in situ remineralisation studies. Clinical studies conducted in children who chewed gum at least three times daily for two or three years show that they have significantly lower rates of decay than children who do not chew gum. Indeed, the American Dental Association has recently provided clinical guidelines for the use of sucrose-free polyol chewing gums in high caries-risk children and adults.

Extrinsic stain reduction
Chewing gum can reduce extrinsic tooth stain, either by removing existing stain or inhibiting its formation, whilst the addition of specific active agents (typically polyphosphates) may provide additional efficacy. However, it should be noted that these types of claims are cosmetic and do not directly affect oral health, and the magnitude of the effect is small compared to bleaching therapies. On the other hand, accelerated oral clearance of staining agents such as tea or coffee, by chewing gum stimulated saliva, could conceivably reduce the formation of extrinsic stain over time and help prolong the benefits of a dental prophylaxis. Interestingly, chewing gum has been found to counteract the short-term sensitivity associated with professionally-applied bleaching treatments, although the mechanism of this effect is not clear.

Effects on plaque and gingivitis
There is evidence that regular use of chewing gum, in conjunction with normal oral hygiene procedures, provides a slight, but significant, reduction in plaque scores. Although one study did not show this effect, in addition, two of these studies showed effects on inflammatory parameters, such as bleeding score or gingival index. A recent systematic review concluded that chewing sugar-free gum provides a small but significant reduction in plaque scores when used as an adjunct to normal plaque control measures. Therefore, any claims regarding effects of sugar-free gum without actives on plaque should be interpreted only as a potential adjunctive effect, not intended to substitute chewing gum as an alternative to regular brushing and flossing.

Active agents for remineralisation/caries

There have been many attempts to improve the inherent remineralising effect of chewing gum-stimulated saliva through the addition of specific active ingredients. See an overview of some of these actives below.

Specific polyol effects
Sugar-free gums are usually sweetened with polyol (sugar alcohol) sweeteners, such as sorbitol, mannitol, xylitol, or maltitol. These polyols have all been certified as safe for teeth by appropriate plaque pH testing; thus, while their inherent sweetness helps stimulate saliva, their rate of metabolism and acid production by the oral (plaque) bacteria is slow and does not cause an effective drop in the plaque pH, so the net effect is an increase in the plaque pH. There has been considerable research to test whether certain polyols show superior efficacy, but a recent systematic review stated it was not possible to distinguish between benefits derived from chewing versus those associated with specific polyol effects.

Calcium and Phosphate salts
Other approaches to improving the inherent anti-caries effect of sugar free gums have focused on the use of suitable calcium or calcium phosphate salts to supplement the natural calcium and phosphate levels of saliva, raising the level of saturation of the immediate tooth environment with respect to these ions to aid
Potential negative effects of chewing gum
It is worth acknowledging that there are some concerns over chewing gum use, including its potential to be a choking hazard in young children, be subject to littering, and exert a laxative effect. Consumers should be reminded not to give gum to children younger than school age and to dispose of chewed gum responsibly. The laxative threshold of most polyol sweeteners used in gum is typically more than 15 g/day, which would require consumption of 10 or more sticks of chewing gum per day to achieve.

Conclusion
The scientific evidence supporting the non-specific benefits of chewing sugar-free gum has been reviewed and endorsed by key dental organizations across the globe including FDI (World Dental Federation), the ADA (American Dental Association) and the EFSA (European Food Safety Authority). Traditionally, preventive dentistry has focused on sugar restriction, plaque removal/oral hygiene, fluoride usage, fissure sealants and education. More recently, these approaches have been modified by improved diagnostic methods to allow early identification of disease, together with an accurate assessment of disease activity. There is an opportunity for chewing gum to be considered as another preventive modality to add an additional layer of prevention by helping maintain the oral ecology in high and lower risk individuals and populations. Whilst it is not the intention of this article to provide clinical guidelines for the use of sugar-free chewing gum, the aim is to inform practitioners so they can accurately answer his or her patients’ questions regarding this topic and be able to provide appropriate guidance about chewing sugar-free gum and its oral health benefits when used as a complement to usual oral care regimens. While chewing gum may not be a treatment for oral diseases, by helping generate a healthy flow of saliva, it may help offset the perturbations in the oral ecology that lead to clinical disease states.

References
Impression of multiple implants using photogrammetry: Description of technique and case presentation

By David Peñarrocha-Oltra, Raquel Rincón, Marta Pons, Leticia Bagán, Beatriz Giménez, María Peñarrocha

Abstract

Aim: To describe a technical application of the position of multiple implants using a system based on photogrammetry (PICabutment®)

After processing patient and implant data, special abutments (PICabutment®) were screwed onto each implant. The PICcamer® was then used to capture images of each implant and the abutments, automatically taking 150 images in less than 60 seconds. From the images, the software automatically interpreted the data and calculated the position of each implant in vector format. This is how the digital technique is described and evaluated. The 3D graphic model of the implant positions was automatically obtained.

Study Design: Three Eurotechnika® dental implants were placed to rehabilitate a 55-year-old male patient with right posterior maxillary edentolysis. Three months after implant placement, the implants were registered using a photogrammetry-based system (PICabutments®). After processing patient and implant data, special abutments (PICabutment®) were screwed onto each implant. The PICcamer® was then used to capture images of each implant and the abutments, automatically taking 150 images in less than 60 seconds. From the images, the software automatically interpreted the data and calculated the position of each implant in vector format. This is how the digital technique is described and evaluated. The 3D graphic model of the implant positions was automatically obtained.

Introduction

Photogrammetry is a novel optical technology that records the position of objects in three-dimensional space and allows the digital reconstruction of objects. It is currently being used in many sciences and fields. In medicine, it has been applied mainly to topographical photosynthesis. The technique depends on the position of the patient’s mouth with a maximum bite (9). Impression was taken and cast in Exocad® (Exocad, GmbH) in 38 CLINICAL DENTAL TRIBUNE Middle East & Africa Edition | February 2015

Results and Conclusions:

Twelve months after loading, peri-implant tissues were healthy and no marginal bone loss was observed.

The clinical application of this new system using photogrammetry for the digital model of multiple dental implants facilitated the rehabilitation of a patient with posterior maxillary edentolysis by means of the identification of abutments screwed on implants with unique individual coding (PICabutment®, PicDaniel). The patient’s occlusal plane was checked by visual observation and the Sheffield test.

The conclusion of this study was that the position was correct, and that the patient’s occlusal plane was verified by visual observation and the Sheffield test.
months after loading, the peri-
implant tissues were healthy and no peri-implant marginal bone loss was observed (Fig. 5). Discussion The provision of ten-
sion-free connections between implants and the prosthetic structures they support is a re-
quirement for medium- and long-term success of implant-
supported rehabilitations. This situation is achieved by carrying out a prosthodontic treatment with good passive fit. Particularly for the recording of the clinical and laboratory proce-
dures involved in fabricating the prosthetic structure, performing precisely and accurately, keep-
ing the margins of error and inaccuracies obtained in the process to a minimum (1,2).

In vitro studies have shown that discrepancies in the super-
structure will be the cause of stress on the implant-supported prostheses and subsequent fail-
ure. As long ago as 1986, Rubino described mechanical failures which he associated with labora-
tory fabrication errors. It is now known that photogrammetry can fabricate the prosthetic structure using CAD/CAM, with reproducible fit and accuracy (13). Photogrammetry has been used in vitro research to test the reliability of other im-
pression techniques (20). As early as 1999, Jenett and Flack (21) described its use for registering the positions of dental implants intraorally. They compared this technique with conventional impression taking, concluding that photogrammetry offered a valid alternative. Since then the number of clinical advances have been considerable but have not been accompanied by any develop-
ment of the application of photogrammetry for the purposes of implant dentistry. The present article presents this new system for registering, simply and pre-
cisely, the positions of multiple dental implants in the process.

Photogrammetry allows the registering of the exact three-
dimensional locations of the im-
plants, transferring all the informa-
tion required to fabricate the prosthesis directly from the pa-
tient’s mouth to a computer file. The technique avoids the in-
convenience accompanying conventional impression tech-
niques. There is no need for impression abutments, implant tak-
ing, transferring abutments, trays and im-
pression materials. The PIC-camera measures angles and dis-
ci

tance between implants, the presence of blood, saliva or any other organic or inorganic residue does not affect me-
asurement precision. Avoiding so many procedures and materials minimizes the probability of errors sav-
time – both the number of visits to the clinic and their dura-
tion – economic cost and patient discomfort in comparison with conventional impression taking procedures.

Photographic and video scan-
ners share some of the advan-
tages of photogrammetry. Scanners 
generate 3D images on the basis of a cloud of points that are able to reproduce surfaces. To join the points they use an al-
gorithm called Rigid-fit, which makes as many points as possi-
ble coincide. Although the practical evidence is limited, theoreti-
cally these successive unions of clouds of points could cause an error. For this reason, reliability diminishes progressively according to the increasing number of implants analyzed (25). But in contrast with intraoral video and photo-
graphic scanners, photogram-
metry generates director vectors of the exact position of the im-
plants in relation to one another. The information that makes it possible to calculate the posi-
tion of the implants is obtained without superimposing pho-
tos, which potentially provides greater precision and a better prosthetic fit.

With the implant positioning de-
termined by the PICcamera and an aligntment approx-
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	next page
The quest for excellence—business as usual?

By Fiona Stuart-Wilson

Most people coming or running a practice like this think that they are providing excellence in their clinical care any justifiably proud of what they do. However, in today’s increasingly competitive environment, it is necessary to exercise its right of choice, clinical excellence and efficiency are no longer enough. The reason for excellence has to be a thread through all of the management and operational activities of the practice. It also has to involve the embracing of change. Excellence is not about maintaining the status quo and carrying on with business as usual. In today’s environment, doing that could mean that you are running your practice slowly into the ground.

Any quest for excellence needs a leader and as the owner or manager of the practice you are in the position to make changes and ensure that your business money towards excellence. In theory this sounds great but putting this into practice can be more difficult. There are several practical steps you need to take, do, but if done it’s what you do that is important but also the way that you do it.

First you need to think about exactly what you are trying to achieve and develop a very clear image as to what the successful practice you are striving for actually looks like and feels like to work in. A surprisingly large number of practice owners do not give this great consideration. You could start by thinking about what ideally you would like patients to say about your practice if they were talking to other people about it. That done, you must then crystallise this into meaningful, measurable and realistic goals across the key business areas of your dental business.

Next you need to tell your staff and others who work with you what these goals are. You also need to be enthusiastic about them so they are expecting them to follow your lead and work at exposing your goals in a motivating and compelling way. It is important for your team to be clearly aware of what successful looks like for you. They will be delivering your ideas.

Now you can start to examine the systems and procedures you have in place and whether these can be improved. This means you need to be clear about what contribution these actually make towards achieving your goals — or not as the case may be. You may have had these systems for some time. They were designed to get you where you are now, and not necessarily to where you want to be, so they may need to be changed or updated. It does not mean they are wrong or inherently bad. It simply means that the world has moved on and we and our systems need to move with it. Take each aspect in turn. Ask yourself the following questions for example:

• The experience of your patients from the moment they contact the practice compared to your idea of what should be happening?
• Does the staff have the right attitudes?
• How effective is your market targeting strategy at attracting the right patients for the practice you want to have?
• Are you investing in the right equipment and technology to attract those patients?
• Are you charging the right fees to allow you to revamp in having examined systems you need to prepare and get on with your plan to make changes.

This is about demonstrating that you are leading the change. You have to demonstrate integrity, enthusiasm and commitment in order for your staff to trust you enough to help you achieve your aims. Things may of course go wrong but we need to learn from the mistakes we make. However, your commitment, enthusiasm and understanding will communicate itself to your team and encourage them to achieve their goals and objectives, overcome obstacles that arise and bring your vision to life.

This does not of course mean you should be doing everything yourself. You should encourage others, help them be creative in their thinking as a team and individually about how things can be done. Above all as a good leader you will be a role model, demonstrate and demonstrate in yourself the characteristics that you want your staff to display. So if you want your team to be committed, motivated and passionate about what they do, you need to be just as committed, motivated and passionate. Good leaders also notice contributions, and make time to ensure everyone feels appreciated and included in the quest for excellence.

All of this involves hard work. It almost certainly involves stepping out of our comfort zone. Real excellence means that we ourselves must also be willing to change and see and do things differently. Thinking of new, better, different, more efficient, more effective ways of doing things that are already working is part of that commitment to excellence just as much as redefining things that are going less well.

For many years people in the profession talked about the management ‘side’ of dentistry. Some still do. Yet the truth is that there is no management ‘side’, it is the total and all encompassing campaign underpinning the delivery of great dental care and those that subscribe to that view are at the forefront of the quest for excellence.

About the Author
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By Dr. Ehab Heikal

How many of your female patients would miss their appointments? The answer is, “not many”.

Do you know that women in USA generally spend about $100 to $130 on their hair appointments and they do this every day for 4 to 6 weeks? That’s at least $1200 per year on their hair! And it’s all out of pocket, without the necessity of being confirmed or reconfirmed. They arrive on their own terms and don’t bother to check with their husbands to see if it’s do. (If you have sold someone else, how much money is spent in our area)?

Perhaps you’ve even had a hairdresser tell you to contact the practice for your appointment with you so they could make their hair appointment! So why is it that hairdressers have a much easier time than dentists? The reason is they have a desire and want for the salon service.

But this is not what you need to do with the patients in your practice. You need to educate the patient on hygiene care, on preventive dentistry, and create desire, want and value for the service.

Getting tough is not enough. You’ve got to discover—and try to eliminate—the reasons why patients skip appointments.

For many practices, missed appointments are like a perpetual flu—always keeping them under the weather.

Sure, some no-shows are inevitable, and if only 4% of your appointments are broken (an accepted average) you’re not suffering much. But it’s unusual for practices to experience skip rates of 10, 20, or 50%. That’s on top of cancelled appointments.

You can fill some empty slots with walk-in and same-day appointments. But probably not all of them, and such substitutes usually won’t generate as much revenue as regular visits. Once you test these factors into account and estimated that no-shows deprived clinics of 14% of anticipated revenue.

No-show isn’t just a money sapper. It wastes the time of staffers who prepare for appointments, deprives patients of needed care, and exposes you to a malpractice risk if an untreated condition worsens. Some doctors have taken the draconian step of charging for missed appoint-
patients whose case requires treatment. Some practices favor a personal touch of old-fashioned telephone calls, but some others note that reminder calls can drop to the bottom of the list on a hectic day. Another problem is that employees often must leave messages on answering machines since most patients work from 9 to 5 and restart the no-showing process the next day. The rise of cell phones, however, is in the tide of a live connection (if call is answered).

Many practices use the SMS which ensures that the patient receives the message even if busy or away. Then they generate a report for the practice.

When you shop for new practice management software, you're better off buying into a system that already interfaces with your billing and scheduling software rather than having someone rewrite a new interface. Your current system may even have a phone reminder tool built in.

Good practice management programs also can generate written reminders that you mail. These may be better for elderly patients who might forget a phone call. For your computer-savvy patients, consider e-mail reminders.

Ideally, every scheduled patient should receive a reminder. Short of that, however, you should at least target the kind of visits that your analysis reveals are most likely to be skipped. And use reminders for your most important appointments—follow-up visits for the seriously ill, new patients, and procedures. The latter two are typically higher paying, and the sort you can't afford to lose.

Whatever system you deploy, issue reminders at least two days in advance. Two days gives you enough time to plug in a new patient. Your ability to improvise, though, depends on maintaining a list of scheduled patients who'd like to be seen sooner.

Address the emotional and mental components

A high-tech reminder system alone won't prevent no-shows. You also need good communication skills.

After all, research has uncovered emotional barriers to keeping appointments. Patients may worry that a treatment or procedure will be uncomfortable, or that they'll hear bad news. By taking time to learn about your patient's fears, you can help them overcome the lump.

Likewise, patients with chronic cases often underestimate the importance of follow-up visits because their doctor merely told them, "I'll see you in three months." That's not enough. You need to explain the consequences of their case and the requirement of follow up.

Patients may mistakenly assume that their absence doesn't hurt your practice—and may even give you a welcome breather on a busy day. This practice is the one you should deliver through your brochure, your Web site, and your employees is this: No-shows disrupt the practice, and that an unfilled slot is a lost chance to help another patient.

Some practices try to deter no-shows by attaching a financial penalty to them. To avoid a $5 or $10 missed-appointment charge, patients typically must cancel the appointment at least 24 hours in advance. It's a get-tough approach that receives mixed reviews. But don't rely on hotels and airlines and not on us.

The policy will get patients' attention, but when you actually charge someone, it's half for public relations. This policy sets a sour tone. It's like announcing, "Welcome to our practice—here are the things that will get you in trouble!"

Consultants also say that many patients balk, (consider it an obstacle and don't show forever) at paying the consequenc...
New A-dec 400 highlighted by radius positioning and style

By A-dec

A-dec 400 combines versatility with elegance. Emphasizing flexibility, A-dec 400 satisfies the need for less complexity and more style at a competitive price point. It’s a solution that complements other A-dec product lines, such as A-dec 500 and A-dec 300.

The new A-dec 400 offers doctors an option for a truly am-bidextrous configuration to accommodate doctor preferences. The Radius delivery and support modules quickly and easily rotate around the chair for complete left/right compatibility.

To elevate treatment room productivity and enhance doctor access to the patient, A-dec 400 optimizes ergonomics with an ultra-thin backrest and positioning of controls and ancillaries, while eliminating unnecessary movement.

“Our approach is to help doctors maximize productivity without sacrificing patient comfort,” says A-dec Project Chief Tom McCleskey. “With A-dec 400, doctors get exceptional aesthetics with features that make it a versatile investment.”

The new A-dec 400 is also designed with well-placed mounting locations for the delivery system and support-side modules. Doctors are able to easily mount a monitor, light, control, cuspidor, and assistant’s arm.

Aside from mounting locations, doctors are able to choose from A-dec’s three dental light offerings and specify factory-installed ancillaries that can be integrated into the delivery system and pre-wired for the touchpad controls. The structure of the new chair exceeds industry standards for strength, rated for a 400-lb. maximum patient load. The new armrest design also gives patients a particularly sturdy and secure grab point.

For customizable styling, doctors can choose between sleek stainless steel upholstery and plush sewn upholstery. A-dec’s wide range of designer color options lend themselves to the A-dec 400 chair’s contemporary aesthetic and robust design elements.

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The Structure of the New Chair exceeds industry standards for strength, rated for a 400-lb. maximum patient load. The new armrest design also gives patients a particularly sturdy and secure grab point.

New A-dec 400 Highlighted by Radius Positioning and Style

www.dental-tribune.com, including a topic page solely dedicated to WOHD 2015. It will also be promoted internationally to spread FDI's message. Among other activities, DTI will help promote WOHD message. Among other activities, DTI will help promote WOHD 2015 through news articles, banners and advertisements in its various international print publications and on the DTI website, www.dental-tribune.com, including a topic page solely dedicated to WOHD 2015. It will also run a special social media campaign in collaboration with FDI.

DTI has been working successfully with FDI for more than a decade and has published and distributed World Dental Daily, the official newspaper of the FDI Annual World Dental Congress, since 2005. The new media agreement, therefore, further strengthens the long-term partnership between FDI and DTI.

In 2015, WOHD 2015 will be celebrated on 20 March. In addition to public awareness campaigns and sponsored oral health-related events, FDI’s member national dental associations, companies and other groups worldwide will be celebrating the day with individually organised events to sensitize people everywhere in the world to oral health issues and the importance of oral hygiene.

As the official media partner of WOHD 2015, the publisher will provide comprehensive coverage of events both locally and internationally to spread FDI’s message. Among other activities, DTI will help promote WOHD 2015 through news articles, banners and advertisements in its various international print publications and on the DTI website, www.dental-tribune.com, including a topic page solely dedicated to WOHD 2015. It will also run a special social media campaign in collaboration with FDI.

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Contact Information

To find out more visit A-dec www.a-dec.com or visit stand 250 at the AEEDC.

DTI joins forces with FDI for 2015 World Oral Health Day

By Dental Tribune International

GENEVA, Switzerland/LEIPZIG, Germany: In order to include the more than two million dental professionals worldwide in celebrating World Oral Health Day (WOHD 2015) next year, FDI World Dental Federation recently signed an agreement with its long-term media partner Dental Tribune International (DTI). Both organisations have joined forces to promote awareness of the importance of oral health on a global scale via DTT’s numerous print and online publications.

WOHD 2015 World Oral Health Day will be celebrated on 20 March 2015. (Image: FDI World Dental Federation)
Support, replenish and protect with the stroke of a brush

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Oral-B, most Dentist Recommended Toothbrush Brand worldwide

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Oral-B Launches Up-To-Date series in MEA Region. More to come in 2015

By Oral-B

Oral-B, the brand of Procter & Gamble’s Oral-B launched a series of Continuing Dental Education events in 2014 for the Middle East region. The events which already took place in Dubai, Abu Dhabi, Ras Al Khaimah, Muscat, Damman, Riyadh and Jeddah will continue to grow in the region in 2015.

The Oral-B brand is a worldwide leader in the brushing market as well as education. Part of the Procter & Gamble Company since 2006, the Oral-B brand includes manual and power toothbrushes for children and adults, oral irrigators, oral care centers and interdental products, such as dental floss. Oral-B toothbrushes are used by more dentists than any other brand worldwide.

P&G Oral Health are pleased to sponsor this scientific exchange seminar for Dentists, Hygienists and Therapists at a choice of different locations and dates during the year 2014 and will continue in 2015. The 2014 events took place at several locations within UAE, KSA and Oman.

The Scientific Relationship Manager for the Arabian Peninsula, Dr. Ashhad Kazi describes the initiative: “The MEA region is very important for Oral-B. Over the last two years we have been striving to deliver top notch education and help improve the overall oral health condition in the region. Our newest innovations of Stabilized Stannous Fluoride in the new Oral-B toothpaste, along with the oscillating / rotating power brushes will help achieve oral health maintenance goals in the region.”

Up To Date Dubai – 31st January 2014 - Gloria Hotel Dubai
Up To Date Dammam – 26th June 2014 - Sofitel Hotel Al Khobar – Corniche
Up To Date Jeddah – 50th October 2014 - Park Hyatt Marina Jeddah
Up To Date Riyadh – 1st November 2014 - Radisson Blue Hotel Riyadh
Up To Date Muscat – 04th November 2014 - Grand Hyatt Muscat
Up To Date Abu Dhabi – 18th November 2014 - Millennium Hotel Corniche Abu Dhabi
Up To Date Ras Al Khaimah – 15th December 2014 - The Cove Rotana, RAK

Oral-B showcased its latest developments at each Up To Date event.

The powerbrush offers several benefits of good oral hygiene