“The edentulous patient is an amputee, an oral invalid, to whom we should pay total respect and rehabilitation ambitions”. Per-Ingvar Brånemark

By Safa Tahmasebi DDS MS

As a professor of surgery and research, P-I Brånenmark is considered the father of modern dental implantology (Figure 1). In the early 50’s he discovered the process of osseointegration, which later was referred to as the direct structural and functional connection between living bone and the surface of a load-bearing artificial implant. (Figure 2)

This discovery was a result of a series of vital microscopic experiments on blood in mobile tissues, bone and bone marrow by placing titanium optic chambers in rabbit’s tibia. Later it was discovered it was extremely difficult to remove these chambers for further use after a period of healing. (Figure 3)

Since then Brånemark and his team conducted numerous research aimed at Orthopedics, joint replacements, plastic surgery and tumor defects. In 1965 Brånemark treated the first human patient Gösta Larson with titanium dental implants who was missing teeth as a result of jaw deformities. Larson passed away in 2006 and used his implants for more than 40 years. (Figure 4 - page 34)

The initial reaction of skepticism and doubt was overcome in 1982 in North America at the Toronto conference on osseointegration. Here the biology, clinical research and applications of osseointegration were presented to the world and since then for 32 years millions of people have been able to benefit from the life changing contributions of osseointegration.

Today the rehabilitation of patients with oral, Maxillofacial and orthopedic impairments has been accepted and adopted by the international community and through a worldwide collaboration and ongoing research and advancements we have gained enormous knowledge for treating our patients. These advancements have allowed the clinicians to apply load-bearing implants with teeth the day of the surgery and this has had a remarkable impact into the quality of the patient’s lives.

In 1989 Professor Brånemark founded the first The Brånemark Osseointegration Center (BOC) in Gothenburg, Sweden (www.branemark.com). BOC’s principal task was to offer management for patients with severe oral, maxillo-facial and orthopedic disabilities. There are only 10 such clinics in the world and in the June of 2013 due to its excellence in dental implant treatment the Dubai BOC was founded by Dr Cotsa Nicolopoulos and Dr. Petros Yovanoglu at the Dubai Healthcare City and named SameDay Dental Implants (www.Samedayme.com). This demonstrates a milestone of progress for the health system in Dubai being able to host a BOC in the Middle East.

*With dental implants & new teeth all in one day my life changed thanks to SAME DAY DENTAL IMPLANTS. I can now
NEW: Philips Sonicare FlexCare Platinum

For outstanding cleaning, even deep between the teeth

Philips has the right sonic toothbrush for every cleaning need. The latest innovation is called Philips Sonicare FlexCare Platinum. Its innovative pressure sensor gives immediate feedback if too much pressure on the brush head minimizes the vibrations. This makes the Philips Sonicare FlexCare Platinum ideal for those of your patients who are worried about using too much pressure when cleaning with an electronic toothbrush. Nine individual settings and intensity levels thereby make adaptation to the individual cleaning requirements possible.

Pressure sensor
This innovative sensor gives simple and intuitive feedback if the brush head is pressed down too hard.

3 cleaning settings
• Clean – ensures optimal plaque removal (standard)
• White – removes discoloration of the tooth surface in 2 minutes, and the front teeth are whitened and polished in a further 30 seconds.
• GumCare – combines 2 minutes in the Clean setting with 1 minute of gentle gum massage for healthy gums.

3 intensity levels
Maximum comfort with the 3 adjustable intensity levels: low (for sensitive areas), medium and high. Each of the 3 intensity levels can be combined with each of the 3 cleaning settings.

Philips Sonicare InterCare brush head
Extra long filaments reach deep into the spaces between teeth and ensure an excellent plaque removal there compared to a manual toothbrush. For better tooth and gum health.

UV-Sanitizer
With the UV light technology from Philips, up to 99% of the bacteria and viruses¹ on the brush head are rendered harmless – in only 10 minutes.

Lithium-ion rechargeable battery
With 3-week working life

¹ E. coli, S. mutans and HSVI, HA
Keeping Hygienists in par with Continuing Education initiatives

By Victoria Wilson, Dental Hygiene Therapist, UK

It is our aim of the Dental Hygiene Tribune MEA to keep you, our valuable members and readers, on par with continuing education initiatives across the region. We will target and focus on the most up-to-date treatment methods available, the emerging scientific research and the current best practice techniques used in dental hygiene.

Hygienists or Dental Care Professionals (DCPs) are ideally positioned to provide comprehensive support to dentists and patients - starting from pre- and post- restorative work through to periodontal treatment, maintenance and long-term continuing care. In order to do this effectively, DCPs need to be continually updating and developing their knowledge and clinical skills, as well as being aware of the new technologies on the market.

I welcome the opportunity to bring my enthusiasm for Dental Hygiene Tribune to Dental Hygienists in the Middle East and offer an earnest commitment to meeting the need for high quality training and ongoing support in our commendable profession.

I am dedicated to raising and representing the Continuing Medical Education (CME) team for Dental Hygiene Tribune members to ensure that your interests are being met. With your support, I look forward to developing new programmes for this publication to further encourage collaboration and clinical excellence in the Hygiene field.

I would appreciate hearing your preferences for CME topics and any other suggestions that you would like to offer.

Contact Information
Ms. Victoria Wilson, Dental Hygiene Therapist
wilson@dental-tribune.me

Maintenance of dental implants for the hygienist

By Biberach/Fiss

Implant dentistry has become more and more prominent in our everyday practice as patients are keen to have implant-borne prostheses than a conventional bridge work or removable dentures. One of the most important factors for long term success of dental implants is the maintenance of healthy peri-implant tissues.

Hygienists are now seeing more of their patients with dental implant and this is only going to increase in the future as implant therapy becomes cheaper. The role of the hygienists has increased in many ways with regards to dental implants. It is important for a hygienist to be able to diagnose peri-implantitis and to have the knowledge to treat simple to moderate peri-implants and to monitor the health of dental implants in the long term as part of the patients regular maintenance.

How do you know when an implant has problems?

It is essential to be methodical when monitoring the peri-implant tissues at review appointments to spot the early signs of peri-implantitis.

The clinical markers that are used to assess the presence and severity of inflammation around the implant are:

- plaque and calculus accumulation;
- inflammation of the peri-implant tissues;
- increase in peri-implant probing depths;
- bleeding on probing;
- suppuration from the peri-implant pocket;
- implant mobility;
- radiographic changes.

When probing peri-implant tissues:

- if the resistance of the soft tissues is increased,
- if there is deepening of the probing depths,
- if there is evidence of suppuration or if bleeding develops

Why CME (Continuing Medical Education) or CPD (Continuing Professional Development) is Important to Dental Professionals

By Victoria Wilson

Defining Continuing Professional Development (CPD) and outlining the need for it for dental professionals through a series of publications from Governing bodies, it can be seen that with proper planning, goal assessment and verifiable CPD activities, one can not only meet government regulations for CPD but gain insight and skill-set for further professional and personal development.

Method

Review an analysis of CPD for dental professionals from online publications related to bodies in the UK, US, Canada, and the Middle East.

Results

CPD can be obtained through a wide range of activities. A structured approach when undertaking the CPD projects of choice, in line with key targeted learning objectives, is key to achieving a noteworthy and credible progression in job performance.

Conclusion

Not only is a minimal amount of CPD required in most countries by law, it can be determined that CPD will not only enhance one's performance and the overall operations of the facility/clinic, but will result in valuable public awareness for the safety and regulated practices of dental facilities in general.

Introduction

What is CME - CPD?

Continuing Medical Education (CME), otherwise referred as Continuing Professional Development (CPD), is the way in which professionals can enhance their knowledge and skills related through a structured approach.

CPD for dental professionals is an obligation in many countries. A mandatory amount of course-related points must be fulfilled in the form of: lectures, seminars, courses, individual study, peer review, clinical audit or E-learning activities. These hours can be recorded on a personal CPD record providing the courses are designed to advance professional development as a dental professional and is relevant to one's practice. (1)

Why is CPD in Dentistry so Important?

Education and qualifications are only the first step towards obtaining a professional career. CPD is an obligation to one's profession - not only for the personal benefits for individuals and clinics, but also for the overall perception and confidence that the public has in the dental industry.

Dentistry is constantly evolving through new methods and technologies to better meet the needs of patients. CPD will ensure that dental professionals continue to be at the forefront of this knowledge. It is important for patient comfort, well-being and safety.

It is also required by law for all registrants working under the local medical authority to undertake a minimum amount of CPD points in order to maintain the licence of the practice. If this minimum is not met by all of the professionals, the licence cannot be renewed.

Verifying CPD points

In some countries, such as the UAE, the Governing body acts to verify the CPD provided. Submission of papers for a CPD event must be approved by Dubai Health Authority (DHA), Dubai Health Care City (DHCC) or Health Authority Abu Dhabi (HAAD) prior to an event.

In other countries, such as the UK, parts of US and Canada, verifying the CPD provider is determined by the judgment of the registrant. It is a common requirement to have to keep documentary evidence in these countries for up to 5 years post CPD cycle. (4, 5)

There will generally be documentary evidence that the CPD has been undertaken with concise educational aims and objectives and clear an...
In ‘bleeding on probing’ trials over 4 weeks, **parodontax** demonstrated significant effects in reducing bleeding gums by 22% (p<0.01)

Bleeding on probing increased after 4 weeks of brushing with the fluoride control toothpaste.

---

**Reduced bleeding on probing index after 4 weeks with parodontax**

<table>
<thead>
<tr>
<th>Change vs baseline</th>
<th>Fluoride-containing control toothpaste</th>
<th>parodontax®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 weeks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22% reduction in bleeding (p<0.01 vs baseline)

---

Helps stop bleeding gums

Adapted from Saxer et al 1994. All interdental spaces from 6 to 6 were tested at baseline and 4 weeks for bleeding on probing on the right side (buccal) and left side (lingual). Findings were recorded as 0=no bleeding; 1=slight/isolated bleeding; 2-marked bleeding. Mean scores were determined. N=22.

Baseline values (Mean SD): Control (fluoride-containing toothpaste) group 24.75 (6.34); parodontax® group 25.40 (5.80). After 4 weeks: Control (fluoride-containing toothpaste) group 26.00 (9.14); parodontax® group 19.80 (7.38). *parodontax® vs control p<0.05.
Every day protection from everyday acids

Modern eating and drinking habits increase the exposure of tooth enamel to dietary acid that can lead to Acid Wear (erosive tooth wear), the biggest contributor to tooth wear. In the early stages of Acid Wear, a patient’s enamel can become translucent, anatomical features can be lost and molar cupping can occur.

GSK collaborated with leading experts in the field to develop Pronamel Daily Toothpaste to help protect patients at risk of Acid Wear. With its optimised formulation, Pronamel is proven in a range of clinical in situ and in vitro studies to reharden acid-softened enamel and protect against future acid challenges.

Not all toothpastes are the same

In laboratory experiments Pronamel’s optimised formulation ensures more fluoride is available at the patient’s tooth surface to protect from the effects of against Acid Wear compared to other toothpastes with the same marked fluoride levels.

Pronamel has been clinically tested in situ to...

- Reharden acid-softened enamel
- Build protection against future acid challenges

![Figure 2: in situ rehardening microindentation study following treatment with dentifrices](image)

Adapted from Hara AT et al. Bovine enamel specimens were subjected to an erosive challenge. This was followed by fixation to palatal appliances and a 4-hour introral phase in 58 human subjects. This phase included tooth brushing with tested products and a further erosive challenge.

![Figure 1: DSIMS imagery to show amount of fluoride at the tooth’s surface in vitro](image)

Shows the lack of any fluoride uptake
Fluoride retained at the tooth’s surface
Increased concentration of fluoride retained at the tooth’s surface

Adapted from Edwards M et al. Dynamic Secondary Ion Mass Spectrometry (DSIMS) of the fluoride content of human enamel exposed to a citric acid challenge followed by treatment for 2 minutes with a range of dentifrice slurries.

Pronamel is proven to reharden acid-softened enamel and provide ongoing protection from the effects of Acid Wear:

- Low abrasivity
- Neutral pH (7.1)
- SLS*-free

Daily protection from the effects of Acid Wear

*Sodium Lauryl Sulphate

References:
New Philips Zoom WhiteSpeed
Light-Activated Whitening System.
A better experience for your patients and your practice.

Philips Zoom In-Office Whitening kit makes treatments easier
Packed in procedural order, you get everything you need for each treatment, including Philips Zoom at-home whitening gel for follow up and maintenance complete in a single package. The Philips Zoom Kit also includes simplified visual instructions.

Unique products for your sensitive patients
Each treatment comes with a Patient Post Care and Maintenance kit that includes the Relief ACP Oral Care Gel. This unique formula combines potassium nitrate for sensitivity relief along with Amorphous Calcium Phosphate (ACP) that helps create healthier smiles through advanced enamel protection. To ensure a more comfortable experience all around, instruct patients to use it for 10-30 minutes after treatment.

New Philips Zoom WhiteSpeed LED Accelerator
The advanced Philips blue LED technology provides approximately 50,000 hours of use—reducing operating costs, downtime and is 40% more energy efficient. The light also emits 100% greater light intensity* with no compromise to safety. Redesigned to be easier to position and more ergonomic, your patients and your treatment will be better than ever.

New support for your practice
Philips Zoom is funding a worldwide public relations campaign to drive patients to dental professionals, and new programs to help you quickly and easily integrate Zoom into your practice.

“With this new light the patient’s sensitivity is minimal, making the procedure much more pleasurable.”
– Juban Dental Care - Baton Rouge, LA

Reveal your patients’ most healthy, radiant smile with Philips Zoom WhiteSpeed

Give your patients the immediate white smile they want and the healthy white teeth they need, with the new Philips Zoom WhiteSpeed. The number one patient-requested professional teeth whitening brand* is clinically proven to deliver superior whitening results in just one office visit. WhiteSpeed is shown to whiten teeth up to 8 shades in 45 minutes; that’s 40% better than a comparable non-light activated system.†

The new Whitening LED Accelerator’s variable intensity settings allow you to customize the output to ensure each patient receives a more comfortable treatment. 91% of patients experienced little to no sensitivity with Zoom WhiteSpeed.‡

Now better than ever — Philips Zoom WhiteSpeed.

* In the U.S.
† Compared to Philips Dash
‡ Results based on 500-person study. Data on file.
Scientists from Norway develop scaffolding to repair severe teeth and jawbone defects

By Dental Tribune International

O

SLO, Norway: Dental researchers at the University of Oslo have developed a new artificial scaffolding that aids bone regeneration. Within a few years, they hope to market their invention to help patients with serious teeth and jaw damage caused by severe periodontitis, manubrial cancer, infection or trauma.

According to the researchers, the artificial scaffolding could be used in particular for cases in which the gap between two bone fragments is too wide, or when large parts of the bone have been damaged through surgical removal or radiotherapy. The scaffolding helps the body repair such serious defects, the researchers explained.

“The new method, it is sufficient to insert a small piece of synthetic bone-stimulating material into the bone. The artificial scaffolding is as strong as real bone and yet porous enough for bone tissue and blood vessels to grow into it and work as a reinforcement for the new bone,” said Prof. Ståle Petter Lyngstadas, Dean of Research and Development at the University’s Institute of Clinical Dentistry.

The scaffolding can be produced like cinder blocks and cut into individual shapes to fit into specific bone defects. It is manufactured from a mixture of water and ceramic powder, which is poured through foam rubber that was designed to look like trabecular bone. The ceramic powder consists of medical-grade titanium dioxide monodisperse nanoparticles, which are also widely used as an additive in sweets, toothpaste and baked goods. Once the mixture has solidified, it is heated to a temperature that causes the foam rubber to dissolve into water vapour and carbon dioxide and the nanoparticles to ligate into one solid structure. It has an open porosity of 90 per cent, containing mostly empty space that can be filled with new bone and blood vessels, which current materials do not provide.

While current materials are degraded gradually, the new scaffolding remains an integral part of the repaired bone, working as reinforcement, Lyngstadasaas explained.

In addition, the generation process could be accelerated by the insertion of bone progenitor cells or bone marrow containing stem cells.

Conventionally, damaged bone is repaired by removing tissue from healthy bones, such as the mandible or hip, for implantation. Patients often experience discomfort and complications after the surgery. This can be avoided by using the scaffolding.

Since the scaffolding has shown positive results in preliminary animal studies, the researchers are currently planning to undertake clinical trials on patients with periodontitis and damaged manubrial bone. They also hope that orthopaedists will show interest in the new method.

The new material was developed in collaboration with Corti-calis, a Norwegian company that specialises in innovative biomaterials. In order to market their invention, the researchers are currently looking for an industry partner.
The causes of bone loss are:

- Occlusal overload;
- Bacterial induced inflammation.

Any occlusal overloading needs to be corrected by the implant dentist. Plaque induced inflammation is initially treated non-surgically but depends on the initial clinical presentation. This involves the removal of dental plaque with or without the use of locally delivered or systemic adjuncts. Lesions with probing depth of 5 mm or more and bone loss of greater than 2 mm would need surgical intervention as recommended by the International Team for Implantology (ITI) consensus report Figure1. A common cause of plaque induced peri-implantitis is excess cement which has been forced into the tissue when the crown is cemented. If the excess cement is not thoroughly removed by the implant dentist, this will induce inflammation of the tissue and possible bone loss. How to maintain dental implants?

It is important that good oral hygiene is performed to maintain healthy peri-implant tissue. The use of toothbrushes, either manual or electric, helps to reduce the amount of plaque biofilm. Floss, including super-floss and interdental brushes is essential for access interproximally. It is very important that oral hygiene for the patient is not made too complicated there by prolonging the time required by using too many oral hygiene aids. In the aesthetic zone, a cross over flossing technique can be used (Figs. 2a-f).

A poor flossing technique or no flossing at all can lead to subgingival inflammation of the peri-implant tissues. It is essential that if a cement retained crown is placed that all the cement is removed as subgingival irritants such as excess cement can provoke an acute peri-implantitis which can cause soreness, swelling, bleeding on probing and eventual bone loss (Figs. 3 & 4).

In premolar and molar areas the use of floss or interdental brushes can be easier for the patient in the case of single unit implant, and in fixed bridgework. Calculus formation on dental implants is very similar to that found on teeth, the only difference is that the abutment and the porcelain are very highly polished, therefore the calculus is not as tenacious as on a natural tooth. When removing supragingival calculus from the implant crowns, it is very important not to use stainless steel scalers as this will damage the titanium surfaces. Therefore it is recommended that one uses a material that is softer than titanium either gold plated or reinforced plastic instruments (Fig. 5). It is very important that an ultrasonic is never used on an implant as this will heat up the implant and could kill the bone that helps integrate the implant. When pocketing has been noted then using the CIST protocol will help treat the majority of peri-implantitis cases. Below is an example of an UR2 with 8 mm pocketing, the site was treated non-surgically with local delivery antimicrobials and with the patient using chlorhexidine gel with the largest interdental brush (Figs. 6a-c). At the 2 week review the pocketing associated with the UR2 has reduced to 5 mm with simple non-surgical therapy any further intervention will need to be reviewed by the implant dentist.

Conclusion

Good oral hygiene performed by the patient has a significant affect on the stability of the marginal bone around dental implants. Therefore regular hygienist appointments are necessary to ensure that your patients are maintaining a high standard of oral hygiene around their dental implants.
Complex dental problems and the contribution of adjunctive orthodontics

By Professor Athanasios E. Athanasion, DDSM

The goal of contemporary dentistry is the achievement of natural dentition under biologically, functionally and esthetically optimal conditions, for the longest possible period. An increasing number of adult people present a variety of complex dental problems, which concern more than one clinical discipline or specialty. These include caries, periodontal diseases, dental trauma, edentulous sites, malocclusions, or their combination.

This article outlines existing orthodontic therapeutic possibilities for adjunctive dental work and emphasizes the importance of teamwork among the general dentist, the orthodontic specialist, and other dental specialists.

Principles of treatment planning for complex dental problems

The need to formulate problem-oriented treatment plans, which address patients’ chief complaint for complex cases necessitates consensus among the parties involved namely the general dentist, the specialist and the patient. Diagnosis must utilize patient’s data, derived from records interpreted by the clinician using strict scientific criteria. On the other hand, treatment planning constitutes an intellectual process where subjective elements are often involved. It is the path that the well-educated and experienced clinician follows in order to maximize the benefits for the patient, which must be contrasted to the cost and risk involved when certain procedures are adopted (1). An essential requirement for successful interaction is that both general practitioner and specialist are in agreement regarding the advantages and limitations of the treatment chosen.

Adjunctive orthodontics

Adjunctive orthodontic treatment is tooth movement carried out to facilitate other dental procedures necessary to control disease and to restore function. It may be an alternative adjunct to general dentistry by providing (a) rehabilitation following tooth migration due to pre-existing periodontal disease; (b) pre-prosthetic orthodontics; (c) treatment of periodontal defects; and (d) orthodontics as an alternative to prosthetics (2).

Orthodontics and periodontics

It has been documented that orthodontic treatment in patients with severe periodontal destruction is no longer a contraindication (3). On the contrary such treatment might even enhance the possibilities of saving and restoring a deteriorating dentition. During the orthodontic movement it is the entire periodontal unit (bone, periodontal ligament, and soft tissues), which moves with the tooth (4). This all-embracing movement has been shown to be beneficial when orthodontic uprighting of tipped molars is undertaken since the crestal bone exhibits predictable and considerable changes (5) (Figure 1). Forced eruption has also been reported to decrease the depth of isolated vertical infrabony defects and to expose tooth structure, thus allowing the prosthetic management of subgingival fractures, caries and lateral root perforations (6) (Figure 2).

Orthodontics and missing teeth

In cases where lateral incisors are congenitally missing and other malocclusion co-exist, in most instances the treatment of choice is the orthodontic movement of the canines to...
Aesthetics and function: Orthodontic - surgical collaboration as a key to success

By Drs Martin Jaroch & Friedrich Bunz, Germany

Oral surgery is an important cornerstone in orthodontic treatment of malocclusions. Tooth movement is only possible to a limited extent and always depends on the physical limit of the maxilla and mandible in relation to each other, as well as on deformities of the jaw in relation to the other facial bones. Anomalies may be congenital or acquired and may affect patients in childhood already. If so, the focus of orthodontic treatment is not primarily on the aesthetic correction, but is guided by functional and phylactic concerns. Efficient occlusion and restoration of maxillary and mandibular function are decisive factors for tooth preservation and prevention of secondary disorders (Figs. 1a–c). Without a doubt, aesthetic improvement, as well as the associated self-consciousness, is the main concern in adult patients, which can be pursued through surgical correction.

Causes of malocclusion

Generally, patients visit an orthodontic practice only after symptoms or significant abnormalities have already presented. Clinically, this results in late mixed dentition or permanent dentition. Relational parameters can elucidate an accurate mapping of the reasons for this malocclusion. In the literature, the causes of malocclusion and the aetiologic structure of the symptoms of malocclusion in orthodontic patients are controversial issues. No explicit information on the percentage of patients with acquired and hereditary malocclusions can be found in a study by Schoop (1981) on the exogenous factors involved in the development of malocclusion. However, from the assessment of individual patients’ symptoms, all symptoms of malocclusion could be associated with aetiological factors only in 48% of patients. Brodmann and Sackel (2001) concluded from Schoop’s report that only 20% of the anomalies were hereditary and thus could not be affected by prophylactic interventions. Accordingly, 80% of malocclusions could be resolved through prevention and better oral hygiene. This idea is contrary to the results of the German Oral Health Study. In this study, a decrease in child-caries was observed. However, this decrease was associated with a decrease in the amount of caries, which was positively influenced by preventive and prophylactic measures.

The varying findings and remarks illustrate the difficulty of clear classification of malocclusion. Nonetheless, the demands of the patient have priority and he expects a symptom-based therapy with stable treatment results. This means that in malocclusion cases that cannot be resolved by functional orthodontics, orthodontic-surgical planning can be done before any treatment is attempted by pure dentoalveolar compensatory intervention. Compensatory dentoalveolar procedures could prevent a surgical operation. At the same time, patients may run the risk of prorated treatment without any long-lasting benefit. The decision for or against orthodontic surgery requires interdisciplinary agreement and reliable treatment goals must be defined in advance (Figs. 2a & b).

Target group for orthopaedic surgery

Nowadays, adults make up the majority of patients in the orthodontic practice. They are generally motivated by high socio-cultural demands and the desire for perfect teeth. In adults who have an obvious discrepancy between their maxilla and mandible, it must be clarified whether the deformities are dentoalveolar or skeletal. Owing to the limitations of conventional orthodontic treatment, skeletal discrepancies can rarely be entirely resolved. In those cases, combined orthodontic-surgical treatment is necessary. During growth, it is mostly possible to treat malocclusions successfully without surgery by purely orthodontic treatment using removable appliances or brackets. Children and young people for whom functional orthodontic treatment has not led to the desired result are treated surgically. Early surgery always carries the risk of unexpected growth pattern or unilateral abnormal hypoplasia and can affect the results of the operation.

Selection of patients

Combined orthodontic-surgical treatment requires not only strong and focused interdisciplinary collaboration, but also absolute acceptance of the therapeutic concept by patients and parents. The treatment is time-consuming and post-operative corrections cannot be excluded. A detailed medical preoperative discussion should inform patients about the risks of combined treatment and the consequences of untreated malocclusions. Malocclusions can cause numerous side-effects, such as back pain and chronic headaches (Figs. 4a & b). In markedly dolicho-facial face types, malocclusions can lead to a pharyngeal constriction, which can manifest as obstructive sleep apnoea syndrome (Hochhan et al. 1997). In adult patients, it is normally useful to determine the amount of malocclusion and force bite using a flat-plane bite splint. The splint is worn for six to eight weeks, and guarantees the identification of the physiologic condylar position. Pursuing orthodontic correction depends on the intended post-operative situation. Therefore, such correction is only dentoalveolar and does not transfer bite forces of the jaw in relation to the other side (Figs. 4a–c & 5a–e). The most favourable position of the maxilla and mandible is assessed on the basis of simulated cast surgery in which the amount of shift is determined. Using these casts, a splint can be fabricated and placed during surgery to fix the determined physiological condylar position presoperatively (Figs. 6a–c).

Teeth and mandibular asymmetry that cannot be clearly classified should be treated with special care. Should clinical records be available only from the age of 16 – whether as a result of erroneous dental records or simply owing to late initial assessment in a specialised practice – accurate early diagnosis of potential unilateral hypoplasia with further growth tendency is essential. According to the German Society of Oral and Maxillofacial Surgery guidelines, a medical examination of the condylar position should be performed by an oral medicine diagnostic is necessary – in addition to inspection, palpation and radiography – to determine the risk of an abnormal growth in time. Through increased uptake in the affected area during scintigraphy, it is possible to draw conclusions about the growth’s behaviour. If the jaw continues to change by abnormally fast growth, it is advisable to postpone surgical treatment until the cessation of growth.

Surgical technique

The choice of technique for the osteotomy depends on various factors. Osteotomy, surgical access to the bone is created, which is split at fixed points. Correction of the bone and bone healing in the new fixed position is accomplished using simulated cast surgery and a fabricated splint. Following surgical modification of the jaw area, it is important to consider the correct position of the jaw and the optimal occlusion. This crucial decision has already been performed by the orthodontist as accurately as possible because the degree of displacement of the jaw depend on achievable occlusion. Furthermore, teeth have an influence on access to the surgical field and wisdom teeth must be removed before osteotomy in certain cases.

Osteotomy can be done on both jaws or can be limited to the maxilla or mandible. However, in many cases it is functional to perform bimaxillary osteotomy and to shift both jaws. Today, generally the entire tooth-bearing part of the jaw is shifted. Segmental osteotomy has not been proven to be very successful in the past and correction of malocclusions is left to the orthodontic treatment partners. In this field of treatment, the Ongweser-Dal Pant surgical technique is recommended. This procedure describes an intra-oral stepted osteotomy at the mandibular rami (Figs. 7a & b). Since Bell and Egger described the possibility of bimaxillary surgery as the “down fracture” technique in 1975, it has been popular and today you can find it as mostly a combin...
nation of Obwegeser–Dal Pont and Le Fort I osteotomy. The bimaxillary approach seems reasonable, since the maxilla and mandible influence each other during growth. However, it is frequently only possible to obtain a very good and risk-free result by using Obwegeser–Dal Pont surgery. Fixation in split osteotomy of the mandible is usually realised by using minimally invasive plate osteosynthesis. In modified techniques of Obwegeser–Dal Pont surgery, a displaced ramius is fixed using osteosynthesis screws only (Hochban 1997; Figs. 8a & b). This modification avoids the complicated surgical removal of osteosynthesis plates.

Operation risk

Any surgical procedure can lead to unexpected complications, which must always be considered according to the risk–benefit principle. Today, the need for osteotomy remains controversial because a jaw deformity is not a serious illness like a tumour, abscess or bone fracture, which is necessarily treated by surgery. Since deformities are often aesthetic corrections and can be classified as elective procedures, operation safety is a chief concern. Isolated osteotomies of the mandible, which present a significantly lower surgery risk, should be the first choice for orthodontic–surgical interventions.

The most significant risk of osteotomy of the mandible is a probability of about 5% of damaging the sensory nerve, called the inferior alveolar nerve. This can cause sensibility problems of the lower lip and chin area (Figs. 9a–c). Additional serious risks are not expected using Obwegeser–Dal Pont surgery and post-operative bleeding can be controlled very safely.

Interdisciplinary collaboration

The literature reviews of work done in the 1970s makes clear that today’s conscientious collaboration between surgeons and orthodontists is not a matter of course. Over the years, orthognathic surgery was considered to be the last option for treating orthodontic cases that could not be resolved using standard treatment techniques. Therefore, operations were carried out based on tolerance of dentoalveolar compensation and likely made further corrective surgery more probable.

Today, in almost all cases of malocclusion, orthodontic treatment is preceded by surgical treatment. Nowadays, the planning of the operation based on simulated cast surgery and the creation of a splint is a very safe method by which to achieve predictable and stable long-term results (Figs. 10a & b). Individual dentoalveolar discrepancies in occlusion can be corrected preoperatively or post-operatively by orthodontic treatment. Therefore, interdisciplinary collaboration is always a benefit for the patient and treatment team.

About the Author

Dr Martin Jaroch
Dr Friedrich Bunz
Aesthetic and Function Dr Bunz – Dr Jaroch & Partner Professional Practice of Orthodontics
Tegingerstr. 5
78315 Radolfzell, Germany

INVISALIGN® CERTIFICATION
RIYADH MAY 17, 2014

- Apply the most healthy orthodontic treatment
- Expand your adult patient practice
- Enhance your competitive edge
- Elevate the patient experience
- Your patients will love it

Dubai Office: +971 4 385 1663
Riyadh Office: +966 56 114 2557
info@invisaligngcc.com

TO REGISTER: PLEASE VISIT
register.invisaligngcc.com

IT IS TIME TO SEE THE FUTURE NOW!

Invisalign uses 3D CAD/CAM technology to visualize the treatment and a step-by-step simulated results.
“The Middle East region is right up there in terms of Global Orthodontic standards”

By Dr. Khaled Abouseada, KSA

It was a pleasure to interview Dr. Nikhil Vaid who could be ranked as one of the key doctors to enrich and strengthen our orthodontic section in Ortho Tribune, bringing it to new heights by displaying a wide screening of Dr. Vaid’s vast crucial achievements. The focal objective was encapsulating the accumulated information I received from him into an easily digestible manner providing a platform for all the diverse ideas, updates, ethics and principles of orthodontic practices and researches Dr. Nikhil Vaid conveyed. Working with the philosophy of placing an attractively remarkable plan to shine light on his distinguished professional orthodontists to paint the path forward for our science-related readers. Dr. Vaid is an innovative leader in the field of Orthodontics and has demonstrated a major role in improving the practice in India, targeting unique researches and development efforts as well as leading growth initiatives.

Dr. Khaled Abouseada: Compared to when you started practice, has Orthodontics developed through the past years? What are the driving factors behind this development?

Dr. Nikhil Vaid: To be very honest I have not been an orthodontist for that long, to see a decade-by-decade shift in the profession. I have been practicing for 10 years. In the last 12 years from when I did start out, the major thrust has been the incorporation of technology in all spheres: Diagnosis, Research, Philosophy and Practice/pliances. A lot of purists feel the skill levels of the contemporary Orthodontist are becoming redundant because of technology; I would like to think otherwise. The skill required and the changing is the only thing constant with any science. Fundamental principles will still govern Orthodontic care delivery, but incorporation of technology will help us improve the quality of life of both the orthodontist and the orthodontic patient. Today Micro implants are the main stay of anchorage control, I only use Self Ligating brackets, because of chair side efficiency. Lingual Orthodontics, Aligners, Stereolithography, CAD CAM and Robotics are the main stay of our teaching and practice protocols. The third dimension is what we have improved precision in these appliances due to CAD CAM and Robotics.

Back to years of study and residency in India, how can you describe those days?

My residency years in Mysores, India at the JSS Dental College & Hospital were literally, to borrow a line from a famous song, the “best days of my life”. Orthodontic training in India is very regimented and even today the accent is mainly on enhancing dexterity skills, which I think are non negotiable as far as any Orthodontic training is concerned. The programme at JSS was very “cerebral” and “clinical”, in the sense, we were encouraged to think, very often, out of the box. This has influenced us to be receptive to new advances, without the dogma of a particular school of thought. The bonding and the camaraderie amongst colleagues as well as the discipline that kept us on our toes, were actually lessons that have molded me to assume greater responsibilities in life.

Do any of your teachers stand out who encouraged you to pursue this career? What would you tell them now?

Well the soul of any teaching programme is the Programme Director or a Guide in a Masters Programme, whatever the nomenclature is in any part of the world. The biggest influence in my life has been my Professor, Prof. E. T. Roy, who has mentored me as an Orthodontist in my years in my Masters programme. He is a strict disciplinarian, and was responsible for influencing my life beyond Orthodontics as well. It’s important to inspire your residents to be complete professionals, Orthodontics is only a part of what we do. The spirit to serve my profession and professional organization is something that he has inculcated in me. Dr Ashok Sinha, Dr Ravi Gurjar, Dr Ravi Sahle, Dr Shailesh Deshmukh and Dr Sripad Nagarsekar have taught me Orthodontics at different stages of my life as an undergraduate and graduate student. My colleagues during my Masters programme, and later, most importantly Dr Meghna Vankedar, Dr Gurkeerat Singh and Dr Jacob John are also responsible for what I am today. I would like to thank each of these individuals for touching my life and promise to make them proud with everything I attempt to do.

What can you tell us about your experience as the president elect of the Indian Orthodontic Society and Editor in Chief of the Asian Pacific Orthodontic Society?

I have just been elected President Elect of the Indian Orthodontic Society, which is amongst the largest Orthodontic Societies globally. We have an obligation to contribute to the knowledge bank of global Orthodontics, and encourage scientific content of the highest caliber. I will be President in the year 2013-14 of the IOS, which will be a time for us to rejoin and commemorate the past, but at the same time, plan to propel ourselves with policies that will enhance our member’s lives with the changing global trends in Orthodontics. I was appointed Editor of the IOS Trends in 2011 and the Chief Editor in 2013. Today the Journal is indexed by multiple indexing agencies. I have an excellent young and enthusiastic team which is committed to the cause of achieving excellence in documentation of scientific data from the Asian Pacific region that is available to orthodontists across the globe at no cost. I have to compliment the past APOS President Dr Loh Kai Woh, for his vision, Dr Kazuo Tanne, President APOS and Dr Bryce Lee, Secretary General APOS, for their support as well as American Orthodontics for being the corporate sponsor of this endeavor for 2013-14.

What golden advice could you provide to orthodontists considering their future careers as Orthodontists?

I don’t know if I’m qualified enough to advice, but I am greatly influenced by a quote of ours, “The difference between the 21st century will not be the ones who cannot read or write but the ones who cannot unlearn and relearn new things.” Science today is progressing at a pace where the global knowledge bank doubles in just a few years. We have to open minds and the willingness to be students all our lives. If we cannot attune ourselves to this aspect, success in every sphere of life will follow.

As having a lot of scientific publications in the field of orthodontics, can you tell us how can we come to a statistically significant scientific conclusion that needs to be published and the benefit of being published?

I believe documentation of every form of scientific data is paramount. That is creating database, which is critical to any form of research and future reference. As long as any form of information serves to enhance the knowledge bank of orthodontics and follows guidelines and procedures of research that are contemporary, it needs to be considered for publication. Statistically insignificant information also can give information that is of clinical relevance. It’s important to understand that phenomenon. With respect to the benefits of publication, I would not dwell on the fact that we need it for career enhancement. It is our contribution to our profession. If Andrews did not publish the “Six keys of orthodontics” or Angle, the “classification of malocclusion”, would we have evolved to where we are today?

It is critical to understand that publishing our work is our obligation to our specialty. We cannot do more, we should not dare to do less!

What are your future expectations in Orthodontics?

I envision a tomorrow, where Orthodontic care will be available in every corner of the world, provided by a specialist Orthodontist. From a health care perspective, the scope of orthodontics should also include interdisciplinary and adjunctive therapies. Collaboration with Sleep Medicine, Plastic Surgery, ENT, Cardiologists and other Dental Specialists will be the tomorrow of Orthodontics. Aesthetic Orthodontics using CAD CAM and Robotics will be a regular feature of our appliances as well as our Diagnostic and finishing protocols. Diagnostic Aids will become 3 Dimensional for a fact. Research in Genetics, Bone Biology and Molecular Genetics will play a significant role in the way we approach the growing patient in the next decade. It is an exciting time to be orthodontists, this is the future in Orthodontics.

Regarding our Middle-East region, as you are an active contributor in many events in the area, what can you say about the Orthodontic mark in the area?

I think the Middle East region is right up there in terms of global Orthodontic standards. I have travelled to lecture in UAE, Jordan, Lebanon and Oman and progressed with the quality of work and enthusiasm in the region.

Conclusion

My main purpose will always revolve around focusing and bringing Professors of the highest level into focusing on enhance quality, ensuring this top quality and therefore creating the ultimate satisfaction for our readers. I hope that our group have gained the trust of our readers and progressed with the best service possible and improving our material are our main components of value. Receiving feedback is always welcome whether positive, negative, thankful or harsh replies, which will always keep us on our toes. I would like to guide us to our next steps. Continuous improvement of this section is the most important, and its growth is our distinct mission, which we hope would be envisaged to meet your needs.

Contact Information

Dr. Khaled Abouseada
Consultant Orthodontist
khaledab@yahoocom

American Association of Orthodontists

American Association of Orthodontists
The 2nd International Students’ Dental Conference 2014

By University of Sharjah Dental Students Association

April 9-10, 2014, saw over 700 students from ten countries gather together at the University of Sharjah College of Dental Medicine for the 2nd International Students’ Dental Conference. The conference was opened by His Highness Crown Prince Sheikh Sultan bin Mohammed bin Sultan Al Qasimi who toured all the exhibits from eight companies such as Listerine®, Crest Oral B and GlaxoSmithKline, asking many questions along the way, before he oversaw the opening ceremonies.

The conference was a huge success for the students of the University of Sharjah Dental Students Association, who created, planned, organized and executed the whole conference of exhibits, poster presentations, oral research presentations and debates. The two debates focusing on the treatment options of endodontics versus implants, and the other debate on where to draw the line between prevention and restoration in cases of incipient caries, drew lots of interest and resulted in lively and sometimes passionate discussion.

Additionally, a number of participation workshops on topics ranging from layering of anterior resin composite, to TMJ, lasers, rotary endodontics, implants, veneers and a suturing clinic gave participants some outstanding hands-on experiences.

All-in-all, the conference was a culmination of very hard work from the Executive Committee of the Student Association and the Organizing Committee. Dean of the College, Professor Richard J. Simonsen noted in his strong praise of the students that he has never seen a more active and giving group of young people in his over 40 years in dental education.

“The is quite remarkable that a group of 20-year-old young students (mainly ladies by the way!) could pull this off!” - Prof. Richard Simonsen, Dean of the University of Sharjah College of Dental Medicine

The main organizer, Rawand Naji, the President of the USDSA was very pleased with the program and participation from countries as far afield as Russia and Poland. “Next year we hope to consolidate this conference into a regular annual highlight on the dental calendar and eventually attract more many students from all over the world to the University of Sharjah” said student-doctor Rawand.

Social events such as a desert safari, go karting, and a dinner cruise in Dubai were added attractions for the international students which also included large contingents of students from the Kingdom of Saudi Arabia, Sudan and Malaysia as well as students from all the local schools.

The President of the USDSA was also supported by the rest of her Board of student-doctors, Mays Faris, Jumana Lisa Irbays, Abber Sha’al, Shourouk Mahmoud, Sally Masoud Manla, Sara Anbari, Deema Rashad and Mohammed Hussein Haider, all from the second-year dental program at CoS. “It is quite remarkable that a group of 20-year old young students (mainly ladies by the way) could pull this off with such success while still studying hard for upcoming final exams,” said Dean Simonsen.

Faculty support was provided by Dr. Karim Sabahi and Dr. Eman Mustafa, and huge support was provided by former USDSA Presidents, Faraj Edber and Hiba Abdulhadi, who were the first to give the credit to the student association leadership, and all the many other students who helped out with the execution of this remarkable conference.


Still lots to see and discover at IDEM

By Dental Tribune International

Singapore: In the presence of Singapore’s Health Minister Gan Kim Yong and senior representatives of Koelnmesse, the Singapore Dental Association, and FDI World Dental Federation, the eighth edition of IDEM Singapore was officially opened on 09 April 2014 at the Suntec Singapore International Convention and Exhibition Centre. The Minister, who graced the traditional Opening Ceremony outside the Exhibition Hall on Level 4 as Guest of Honour, congratulated the organisers of the show that, in his words, “has evolved to be a ‘must-attend’ event for all dental healthcare professionals and related industries in the Asia-Pacific region.”

Praise was also given by Singapore Dental Association’s President Dr Kuan Chee Keong, who said that the ongoing support of Gan’s Ministry and other sponsors is a testament that IDEM has firmly consolidated its status as the focal event for the Asia-Pacific dental community. “Besides the opportunity to interact with friends and dental professionals from around the world, IDEM also offers the opportunity to share knowledge, ideas and practical applications in dentistry,” he said.

IDEM 2014 is poised to be the largest dental show ever to be held in Singapore since it was launched in 2000. According to Koelnmesse’s Vice President of Asia Pacific, Michael Dreyer, 50 per cent more dental manufacturers and distributors have signed up for the event, which is being held over the weekend at the recently renovated Sands Convention Centre. Reflecting greater interest from industry players in the Asia Pacific region, national pavilions from China and Japan are also held throughout the days.

Attendance figures are also expected to increase by 12 per cent, with many new visitors coming from nearby countries like Cambodia, Myanmar and Taiwan. “Not just a place where East meets West, Singapore is also increasingly being considered a gathering point for different parts of the East to meet one another,” Dreyer said.

“...IDEM also offers the opportunity to share knowledge, ideas and practical applications in dentistry.”

Aside from the trade fair bustle, clinical presentations as part of the scientific programme will continue today at Level 4 with lectures and workshop focusing on fields like prosthodontics and orthodontics. A special presentation by US dentist Dr Barry Freyberg on 05 April 2014 at 4.30 p.m. focused on the detection and prevention of oral cancer, which is among the few types of cancer which are currently on the rise worldwide. At the Dental Tribune Study Club Symposium at booth 6P-22, Singapore’s own prosthodontic expert, Dr Stephen Soo of Specialist Dental Group, will provide insight into CAD/CAM and how its use can benefit workflow in dental practices.

New concepts and methods for dental labs will be discussed at the Dental Technicians Forum, one of the new educational formats specifically targeting other members of the dental profession. In addition to these presentations, lectures for dental hygienist/therapists were also held throughout the days.
Dentistry – your dream profession

At Danube Private University, students undergo a six-year course in dental medicine, and on completion of the course are awarded the internationally recognized degree Dr. med. dent. This elite course of study at the leading edge of medical and dental science, utilizing state-of-the-art medical and dental equipment, practical facilities and our in-house clinic, stress to both challenge and support its students. We want our graduates to be among the acknowledged leaders of their profession. The dental faculty of the University includes many highly respected scientists who take great pleasure in being a part of a new, innovative project in basic dental studies that is of particular benefit to society – led by our Chancellor, Professor Dr. Dr. Dieter Müssig and our Dean, Professor Dr. Dr. hc. Andrej Kielbassa.

In addition to instruction in medical and dental subjects, the President of the University, Honorary Consul M.B. Wagner-Pischel, is dedicated not only to the achievement of excellence in research, instruction and innovation, but also to the holistic education of the young people, ensuring that they receive a solid grounding in the arts, literature, science journalism and music, as well as training in empathy. The aim is to promote the well-rounded development of the young people, and equip them with positive approaches for their subsequent career that enhance their communicative intelligence. Dental health and personal care and hygiene play a key role in how people are perceived today. Beauty and mindfulness are perceived more than anywhere else in oral and dental health. A good dentist can be compared to an artist, as she requires an exceptional understanding of form and colour as well as spatial visualization skills. When combined with the state of the art in medical and dental knowledge, the result is uncompromising excellence in patient treatment.

For President Wagner-Pischel, a life spent in the exercise of a profession about which one is passionate is an important and meaningful life commitment as well as a significant contribution to the welfare of society as a whole.

“Our students at Danube Private University have excellent life and education opportunities. We offer them a top dentistry course equipped with state of the art technology that focuses on students’ needs and values them above all else, while upholding the finest traditional humanistic values. Danube Private University emphasizes not only medical and dental science, but also human interaction among students and instructors as well as responsibility to both patients and society,” explains M.B. Wagner-Pischel, President of Danube Private University.

To date, the student body of Danube Private University is made up mostly of the children of dentists and doctors from German-speaking Europe. Young people from all over the world are interested in studying at Danube Private University. In response, we are offering a preparatory course of study for students outside of German-speaking Europe.

Composite Veneers and Masking Discoloration; About Red & White Aesthetics; Direct Veneers Diastema Closure; Virtual Articulator and CAD/CAM Designing Workshop.

The second day of the conference will feature the new Dental Hygiene Seminar focused entirely on the Dental Hygienist providing the latest in Periodontal Instrumentation and Oral Prevention and Management of Denine Hypersensitivity.

Additional to the knowledge delegates will exchange, all attendees will benefit from the networking opportunities in the cozy atmosphere provided by Jumeirah Beach Hotel where you can meet your colleagues from across the globe while lunching at Dubai’s best restaurants.

All Dentists, Dental Technicians and Dental Hygienists are welcome to get the most updated scientific exchange and view the latest technology, trends and developments in CAD/CAM & Digital Dentistry. The future is here and all are welcome to join.
Failure to provide appropriate treatment of occlusal trauma in patients with chronic periodontitis may result in progressive bone loss.

Subsequent absence from the dental arch of impacted permanent teeth is not an indication for their prosthetic replacement but rather a sign for the start of their orthodontic treatment and alignment into their natural position (9).

In cases of extreme anterior overbite, direct trauma to the gingiva from the incisal edges of the mandibular incisors may result in palatal recession of the maxillary incisors (Figure 5). Similarly, in severe Class II, division 2 malocclusions with linguoversion of the maxillary incisors, functional trauma can cause marginal recession of the labial gingiva of the mandibular incisors. This recession, although not the result of periodontal destruction, can result in a significant loss of attachment.

Clinical observation suggests that when crowding causes overlapping of adjacent teeth, the interproximal space may be minimal, root proximity may occur, and the quality and amount of bony support may be compromised (Diedrich, 2000). This is a poor environment for tissue health. The removal of plaque and subgingival calculus from the inaccessible proximal space may fail despite careful application of prophylaxis procedures. Orthodontic intervention can improve the anatomy and functional environment and may limit the recession.

Conclusions

Provision of adjunctive orthodontic treatment should be characterized by the following provisions: (a) Knowledge of the clinical boundaries of general dentistry and of any other dental specialty involved in maintaining natural dentition under biologically, functionally, and esthetically optimal conditions; (b) establishment of two-way, structured, and continuous communication between generalists and orthodontists concerning the contribution of specialisation care to the oral rehabilitation; (c) assessment of the cost-benefit relationship concerning treatment fees and duration, cooperation, inconvenience, discomfort, pain, and difficulty; and (d) diagnosis and treatment planning relying on strict evidence-based criteria.

References


About the Author

Dr. Athanasian is Professor and Program Director of Orthodontics, Dubai School of Dental Medicine, United Arab Emirates and Professor of Orthodontics Aristotle University of Thessaloniki, Greece. He is former President of the World Federation of Orthodontists and the European Federation of Orthodontists.
bite into my food without pain & with confidence”, Said P.V Shah an elderly man who received his oral rehabilitation in Dubai by Oral Maxillofacial Surgeon Dr. Costa Nicolopoulos at Same-Day Dental Implants. Since 1991 Doctor Nicolopoulos has been practicing as a full time Maxillofacial & Oral Surgery specialist concentrating on immediate loading of dental implants. (Figure 5).

“Less is more, that is our ambition when it comes to dimensions and numbers of anchoring elements” says Per-ingvar Brånemark. In ordinance with the founding father of modern implants we can now install a full set of teeth on only four implants thanks to the new advancements in implantology. This total rehabilitation technique for the edentulous patient known as the All-on-4® treatment concept, is a well documented surgical and prosthetic medical procedure.

Clinics like The SameDay Dental Implants Clinic utilize this treatment protocol allowing patients to have their implants and teeth placed all in the same day as opposed to the conventional technique where dental implants are loaded with teeth usually two or three months later. (Figure 6)

Every year all the BOC clinics from around the globe are invited to the Annual Brånemark Ossointegration Center meeting in Gothenburg Sweden to pay respects and tribute to the man who started it all. (Figure 7)

“It is the works of Professor Brånemark sixty years ago that allows us to change our patients lives on a daily basis”, said Dr. Costas Nicolopoulos at the ABOC annual meeting 2014 in February. Here SameDay Dental Implants Clinic was given the Leading Dentists of the World award as a special member at the ABOC meeting 2014.

While new advancements in the medical and dental world impact our patient’s lives, one must not forget that the basis of this invention lies within a man who saw a future while living in the past. (Figure 8)