London, UK: The CEREC Omnicam was bestowed with the award for the most innovative product at the recent Clinical Innovations Conference which was held on 17-18th May 2013 in London, UK, presented by Mash Seriki, CEO of Healthcare Learning: Smile-on.

The Clinical Innovations Conference is now in its 10th year and in keeping with the ethos of the event the awards allow the profession to celebrate the latest innovative products in aesthetic and restorative dentistry. Healthcare Learning: Smile-on invited the dental industry to nominate their products to be judged by a panel of experts.

CEREC Omnicam demonstrates Sirona’s Power of Innovation

CEREC Omnicam demonstrates Sirona’s Power of Innovation. CEREC Omnicam generates full colour scans of intraoral surfaces without the need for a powder coating. Operating the camera is simple and intuitive. The imaging functionality and camera dimensions have been ergonomically designed. The smooth operation of CEREC Omnicam is no more complicated than taking a video. Three features of the CEREC Omnicam stand out in particular: it supports video streaming, it digitizes the structures of the jaw in their natural colour; and it does not require a powder coating of the tooth surfaces.

CEREC improves efficiency and patient experience

CEREC is a great practice builder. With a busy lifestyle patients are impressed by the single appointment required for the fabrication of a permanent crown or bridge; the life-like appearance of their new restoration is fantastic with an incredible fit. There is no need to place temporary restorations in the majority of CEREC cases, allowing the restoration to be created and fitted in one appointment. CEREC has significantly improved the quality of treatment for patients, as well as enhancing the efficiency of the dental practice.
5th Dental Facial Cosmetic International Conference

Joint Event With American Academy Of Implant Dentistry, 2nd Global Conference 08-09 November 2013, Jumeirah Beach Hotel Dubai, UAE

Shakira Becomes Ambassador Or Tooth-Whitening Products

By Dental Tribune International

CINCINNATI, USA / Procter & Gamble, international consumer products and health care products, has announced that it has entered into a partnership with Colombian singer-songwriter and dancer Shakira. Yesterday, the musician was named new global spokesperson for the company’s Oral B and Crest 3D White collection.

As the global brand ambassador, Shakira, who is also a member of President Obama’s Advisory Commission on Educational Excellence for Hispanic, will help launch the latest additions to the collection, appearing in the brand’s print and television advertising as well as public relations efforts.

The campaign will kick off worldwide in the fall of 2013.

Stephen quinine, global marketing director at P&G, said that the company was excited to have Shakira represent its brand. “As an award-winning artist and beauty icon, she embodies the true spirit of the multidimensional woman, and always does it all with a brilliant smile on her face,” he said.

In addition, Shakira announced that the partnership will include support of children in Colombia through her Barstof Foundation, which currently provides education and food to over 6,000 impoverished children in Colombia and is expanding its work to other countries, including newly launched projects in Haiti and South Africa.

The partnership is Crest 3D White’s first celebrity global partnership.
Modern life can be challenging.

Modern, healthy lifestyles and dietary habits often mean an increase in the consumption of acid-rich foods and drinks. However, experts believe that as few as 4 acidic challenges a day can put patients at risk of Acid Wear. In addition to giving behavioural advice (e.g. diet and brushing), your patients may also benefit from a daily toothpaste that can protect enamel from these multiple acid challenges.

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

Daily protection from the effects of Acid Wear.

CPD Dubai Runs First Event

By Dental Tribune Middle East

Dubai, UAE 10th May 2013 saw ‘CPD Dubai’, a new CPD/CME provider in the region, hold their first event at The Address Hotel, Dubai Marina. The event catered for the whole dental team (dentists, hygienists and dental nurses) and covered the management of medical emergencies in dental practice.

Managing Director, Nicolas Bell commented, “We felt it was important that our first event here should be a topic that all dental practice staff could attend. When researching the market, the feedback we heard from dental professionals at all levels is that although there are a number of ‘conference’ and ‘showcase’ type events run in Dubai there is a lack of full-day, high-quality training events that focus on topics relevant to general dental practice. This is what CPD Dubai aims to provide and we are building up a strong network of speakers to enable us to put together high quality events, predominately using specialist speakers at the end of this year and early 2014.

We have an excellent speaker flying in from the UK in October to run a couple of training events. Dr Raj Johal is a leading authority in sleep-related breathing disorders and lectures throughout the UK and abroad. This is a really interesting topic for dentists to get involved with and it can be both professionally and financially rewarding. There is growing public awareness of sleep-related breathing disorders and the treatments available to combat them. Provision of mandibular advancement splints, constructed by a dentist, can offer an effective solution to conditions such as simple snoring right through to obstructive sleep apnoea. The one-day training programme will give dentists a comprehensive understanding of the topic and will enable them to comprehensively assess patients and to treat suitable candidates safely.”

Claire Wilson, a dental hygienist at Virginia Dental Clinic in Dubai attending the training, said, “The speaker was fantastic, very informative. The venue was brilliant too. I couldn’t fault the day. I’m really enthusiastic about taking what I’ve learnt back to my colleagues in my practice and I’m hoping to come on more courses.”

Hannah Kearney, a dentist at the Dubai London Clinic said, “I really enjoyed the event. Dr Raj was an excellent speaker, who made sure everyone felt involved and delivered very engaging training. The programme was perfect for me as it counts towards both my accredited CPD hours for my DHA licence and helps me fulfil one of the ‘core topics’ required by the General Dental Council in the UK so I can maintain my license at home too.”

Nicolas Bell, of CPD Dubai, agreed, “It’s not just UK licensed dentists based in the UAE though. Because of the attractiveness of Dubai as a destina-
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Immediate Rehabilitations Of Atrophic Jaws Using Tilted Implants

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By Enrico Agliardi, Matteo Clerici, Matteo Consolini, Davide Romeo

Since many years, rehabilitations according to the Brånemark protocol (Toronto-Oslo bone level standard in case of full-arch fixed implant hybrid prostheses 1. This approach consists in the delivery of six implants, axially placed in the pre-maxilla or in the interforaminal region of the mandible, supporting a fixed bridge with bilateral distal extension (costumers). 2. Implant and prosthetic success rates were very high in the long-term, exceeding 20 years of follow-up 3-5. The original protocol required a loading period of at least 3 months for the mandible and 6 months for the maxilla, necessary for the osseointegration of the implants before the prosthetic phases can start 1. Professor Brånemark, who stated the first protocol for implant dentistry 1, considered that period of time sufficient for the integration of the implants. Today, this perspective is no longer fundamental for the final success of the rehabilitation and implants can be loaded immediately after their placement 6-8.

In fact, as testified by recent consensus reports and systematic reviews 9, 10, full-arch rehabilitations and immediate or very early provisional prosthetic phases are feasible. 2. The predictability of this approach is due to well-devised surgical techniques and specific implant placement. The key factor for the immediate function is the bone quality and this enables clinicians to find a solution without waiting for the osseointegration of the implants. Implants can be inserted and loaded immediately, and there is no need for a long healing period. However, a good bone quality is not enough, and the implant system must be able to support a fixed prosthesis.

Tests on models and by finite element analysis performed on specific angulated implants showed that implants may increase the stress to surrounding bone 11. Tilted fixtures and achieve higher levels of osseointegration of the implants 12.

One of the innovative aspects of this technique is the inclination of the dental implant, which offers surgical and prosthetic advantages. By tilting the implants, it is possible to place longer fixtures and achieve higher levels of primary stability because of the greater implant surface in contact with the bone 13. Furthermore, the area of emergence of the inferior alveolar nerve and the anterior wall of the maxillary sinuses are characterized by a good bone quality and this enables clinicians to find a useful prosthetic support. Therefore, when implants are tilted distally, the prosthetic contra- lobe is also relieved. Further prosthetic consequences from implant inclination consist of an increased interproximal distance, the creation of a more regular prosthetic polygone and an increase in the antero-posteri- or (AP) spread 17 compared with the Toronto-Brånemark rehabilitation, especially in mandibles of a rectangular shape. With the reduction of the number of platforms, it is easier to achieve a proper prosthetic fit, both for the provisional and for the final rehabilitation. Patients can maintain optimal levels of oral hygiene because of the fewer number of surfaces and the wider distance between implants. A provisional cemented restoration is simplified and the occlusal relationship is better maintained 18. Nevertheless, the risk of implant failure still exists.

One of the biggest advantages of using tilted implants is the maintenance of the alveolar bone. In fact, tilted implants have been shown to increase the bone density around them. Because of this, the use of tilted implants has been associated with a lower risk of implant failure compared to conventional implants. However, the long-term success rate of tilted implants is comparable to that of conventional implants, and it is important to consider the specific indications for each type of implant.

Immediate full-arch fixed prosthesis

Immediate loading procedures have gained high popularity among clinicians. The reduction of total time of treatment and the possibility to deliver a functional implant bridge few hours after the surgery represent a notable advantage for patients. Therefore, partial edentulous patients with a failing residual dentition can avoid the psychological trauma and discomfort of a transitional removable prosthesis 21.

The rehabilitation of edentulous jaws is often complicated by a reduced bone quantity, especially in posterior region, because of the pretreatment of regional bone. 22, 23, 24. To face these limitations, clinicians have different therapeutic options, such as long-distant cantilever bridge 25, 26, the use of short fixtures 27, 28, and bone augmentation 29, 30. In some cases, the use of ramus branches 31, 32 or the zygoma 33, 34, suggests the use of zygoma implants. Nonetheless, the use of tilted implants may increase the stress to surrounding bone 35. Tilted fixtures and achieve higher levels of osseointegration of the implants 36.

In our case report, a 62-years old male patient was referred to our office with a precise chief complaint: fixing his failing dentition without going through multiple sur- geons and in a relative short period of time (Fig. 1). His functional and esthetic demand was high, but he has financial limitations. He has re- movable partial prostheses in both jaws, but now the mobility of these prostheses with the associated para-functional periodontal disease has compromised his comfort and function 37. Therefore, he was not satisfied of his actual smile. After discussing possible solutions with the patient, we decided to exclude extensive bone grafts (sinus lift) on his mandible, to use the residual bone available, restoring both arches with a hybrid titanium pros thesis supported by two anterior axial and two posterior angled fixtures 29, 30, 31, according to the All-on-4 concept 32. Final prostheses will be realized with titanium CAD CAM framework with integrated screws and metal crowns 34, 35. 36. 37. (Fig. 2a, 2b, 2c). The use of the zygomatic arch and an increase in the anteroposterior dimension of the rehabilitation 38. In this case, the augmentation of bone crest was done in keratinized gingiva starting from the anterior molar region (Fig. 3a). The augmentation was performed by bone grafting from the anterior region to controla the residual bone available, restoring both arches with a hybrid titanium pros thesis supported by two anterior axial and two posterior angled fixtures 29, 30, 31, according to the All-on-4 concept 32. Final prostheses will be realized with titanium CAD CAM framework with integrated screws and metal crowns 34, 35. 36. 37.
Intra-oral view showed few remaining teeth in the upper jaw and residual roots on the mandible. Partial removable prosthesis did not provide comfort during mastication and aesthetic appearance anymore.

3a and 3b Occlusal view of both arches with an adequate amount of keratinized gingiva.

4 Panoramic x-ray evidenced bone loss in both arches due to chronic generalized periodontitis, with horizontal resorption and endo-poro lesions in the mandible. The miniscus sinus pneumatization did not allow posterior implants placement without a preliminary sinus augmentation procedure.

5a and 5b Note the inclination of the posterior surgical site compared to the anterior one. Thanks to the inclination, the posterior implant can be placed following the anterior sinus seal, getting an high level of primary stability.

6 Occlusal view showing implants distribution along the anterior mandible. All implants have been placed with a 50 Newton torque. 30 degrees abutments are inserted in posterior laparic incisors.

7 Verification of passive fit of titanium CAD/CAM frameworks.

Fig. 8 Intact maxillary sinuses, after the surgical elevation, in an underprepared surgical site to increase primary stability.

Fig. 9a and 9b Anterior implants are actually inserted in a cap of lateral incisors.

Fig. 10 Occlusal view of mandibular implants with abutments.

Fig. 11 Provisional acrylic prosthesis containing ten teeth were delivered three hours after the surgery.

Fig. 12a and 12b Full occlusal contacts are limited between canines with no lateral excursions.

Fig. 13 Verification of passive fit of titanium CAD/CAM frameworks with nano-hybrid composite tooth and using the Bruxaire™ Implant.

Fig. 14a and 14b Final bridges containing 12 teeth.

Fig. 15a and 15b Occlusal view of final prosthodontic rehabilitation with limited posterior cantilevers.

Fig. 16a Lateral view of patient’s smile with the final restorations.

Fig. 17a, 17b and 19b Occlusal view of final prosthodontic rehabilitation after one year of loading showing implants distribution and bone level maintenance.

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Fig. 18 Occlusal view showing implants distribution along the anterior mandible. All implants have been placed with a 50 Newton torque. 30 degrees abutments are inserted in posterior incisors.

Fig. 19 Panoramic radiograph after one year of loading showing implants distribution and bone level maintenance.

Fig. 20 Occlusal view of mandibular implants with abutments.

Fig. 21 Provisional acrylic prosthesis containing ten teeth were delivered three hours after the surgery.

Fig. 22a and 22b Full occlusal contacts are limited between canines with no lateral excursions.

Fig. 23 Verification of passive fit of titanium CAD/CAM frameworks with nano-hybrid composite tooth and using the Bruxaire™ Implant.

Fig. 24a and 24b Final bridges containing 12 teeth.

Fig. 25a and 25b Occlusal view of final prosthodontic rehabilitation with limited posterior cantilevers.

Fig. 26a Lateral view of patient’s smile with the final restorations.

Fig. 27a, 27b and 29b Occlusal view of final prosthodontic rehabilitation after one year of loading showing implants distribution and bone level maintenance.

Legends
Fig. 1 This 62 years old patient presented with a clear chief complaint: “improve my smile with a fixed denture.”

Fig. 2a and 2b Occlusal view showed few remaining teeth in the upper jaw and residual roots on the mandible. Partial removable prosthesis did not provide comfort during mastication and aesthetic appearance anymore.

Fig. 3a and 3b Occlusal view of both arches with an adequate amount of keratinized gingiva.

Fig. 4 Panoramic x-ray evidenced bone loss in both arches due to chronic generalized periodontitis, with horizontal resorption and endo-poro lesions in the mandible. The miniscus sinus pneumatization did not allow posterior implants placement without a preliminary sinus augmentation procedure.

Fig. 5a and 5b Note the inclination of the posterior surgical site compared to the anterior one. Thanks to the inclination, the posterior implant can be placed following the anterior sinus seal, getting an high level of primary stability.

Fig. 6 Occlusal view showing implants distribution along the anterior mandible. All implants have been placed with a 50 Newton torque. 30 degrees abutments are positioned in the posterior implants to correct their inclination, while 17 degrees abutments are screwed on the anterior fixtures for a favorable emergence of the prosthesis screw on the palatal side.

Fig. 7 Post-extraction gaps were filled with autogenous bone before flap closure. The flap was sutured in a way to create a minimum 2 mm collar of keratinized gingiva all around every abutment. This peri-implant seal will be very important for the long-term maintenance of the entire rehabilitation.

Fig. 8 Occlusal view showing implants distribution along the anterior mandible. All implants have been placed with a 50 Newton torque. 30 degrees abutments are positioned in the posterior implants to correct their inclination, while 17 degrees abutments are screwed on the anterior fixtures for a favorable emergence of the prosthesis screw on the palatal side.

Fig. 9a and 9b Anterior implants are actually inserted in a cap of lateral incisors.

Fig. 10 Occlusal view of mandibular implants with abutments.

Fig. 11 Provisional acrylic prosthesis containing ten teeth were delivered three hours after the surgery.

Fig. 12a and 12b Full occlusal contacts are limited between canines with no lateral excursions.

Fig. 13 Verification of passive fit of titanium CAD/CAM frameworks with nano-hybrid composite tooth and using the Bruxaire™ Implant.

Fig. 14a and 14b Final bridges containing 12 teeth.

Fig. 15a and 15b Occlusal view of final prosthodontic rehabilitation with limited posterior cantilevers.

Fig. 16a Lateral view of patient’s smile with the final restorations.

Fig. 17a, 17b and 19b Occlusal view of final prosthodontic rehabilitation after one year of loading showing implants distribution and bone level maintenance.

References
Air Polishing

mCME articles in Dental Tribune have been approved by HAAD as having educational content for CME credit hours. This article has been approved for 2 CME credit hours.

By Salim Rayman, RDH, MPA, and Elvir Dancer, DDS

The concept of air-powder polishing is based on a technology developed by Dr. Robert Black in 1945. Black invented a device called the Air Dent, which used compressed air, water and a high-speed abrasive. The patient was kept in a reclining position from pain from care preparation, making access easier.

While the Air Dent presented many problems, the technology represented the first step in air-powder polishing devices. Air-powder polishing was accomplished by abraded or bared surface preparation through the use of air-powder or air-water through a handpiece nozzle. This process is still being used today for the preparation of restorations and prosthodontics.

The handpiece, or nozzle, through which the slurry is propelled is activated by a foot control. The air pressure produced when the nozzle is activated is measured in pounds per square inch (psi), depends on the type of air-powder polisher being used.

Air-powder polishers are manufactured as separate handpiece units that attach directly to the air/water control on the dental device or in combination with a ultrasonic scaler.

**Indications for use**

Contraindications: a cosmetic procedure designed to remove extrinsic stains from the enamel surfaces of the teeth. It can be a powdery formulation by abrasion and erosion of the extrinsic stains.

The most common technique for stain removal is rubber cup polishing. This technique uses an abrasion agent and a slow revolving polishing cup to abrade stains from the tooth surface. Air-powder polishing is accomplished by erosion of extrinsic stains by suspended abrasives within a water slurry. Kinetic energy propels the air-powder combination through the nozzle onto the tooth surface, removing stain (Fig. 1a, b).

The air-powder polisher is shown to be efficient, safe and effective in removing extrinsic stain and plaque biofilm from tooth surfaces. It is equally effective in decreasing root surface roughness or instrumentation. It is also reported to remove plaque biofilm and staining as effectively as a rubber cup and does so in less time.

Patients often exhibit extensive stains on root surfaces, specifically on areas of recession or at the cervical-crest toannular junction. Removing these stains with a brush has been shown to reduce root structure. However, when stain removal is for aesthetic reasons, the removal must be performed to patient comfort in a manner that is free from patient discomfort.

The air-powder polisher removes extrinsic staining without damaging the tooth structure in semipermanent fillings if the instrument is used properly.

Different air-powder polishers are made of aluminum trihydroxide, which has a Mohs hardness number of 6.

Sodium bicarbonate is safe for use on enamel, amalgam, gold, porcelain, implants (titanium) and orthodontic materials. However, its use should be avoided on all types of composites, glass ionomers and luting agents (cements). When used on implants, air-powder polishing with sodium bicarbonate may not be detected subjacent to the implant surface, thus making it possible for decomposition of implants.

A sodium-free powder for air-powder polishing is available (Fig. 2) (Jet Fresh from DENTSPLY Professional, York, Pa.). Developed for patients who are sodium intolerant, this powder is made of aluminum trihydroxide, which has a Mohs hardness number that is approximately the 6 o’clock position. It may be used on all restorations that can be altered by extrinsic abrasion, staining and pitting.

Contraindications for using the air-powder polisher also include patients taking potassium, diuretics or steroid therapy—all of which can disrupt the acid/base balance. Contraindications for use of the air-powder polisher also extend to the hard and soft tissues; therefore, the dental history assessment is paramount. Hard tissue that presents with any composite restorations, sealants or glass ionomers should be avoided on all restorations because of susceptibility of these materials to surface roughness or pitting.

Porcelain margins and margins of all restorations can be altered by extrinsic abrasion. Exposure to the abrasive particles on the air-powder polisher can cause enamel erosion or small blemishes, particularly on posterior teeth.

Patient preparation is with utmost importance that before using the air-powder polisher, clinicians must prepare themselves and their patients. Patient preparation would include a thorough history and explanation of the procedure, review of medical history and taking of blood pressure. The clinician should place a disposable or plastic drapes over the patient’s clothing, provide the patient with safety glasses and conform mental status.

After cleaning the patient, the clinician should make the patient aware that exposure to the abrasive spray, which can dry the lips.

Research has confirmed that when the clinician performs air-powder polishing, aerosol microcontaminants can cause surfaceroughness, because of sodium bicarbonate ingested during air polishing is avoided because of the risk of contamination from the aerosol, the use of a high-speed evacuation system is necessary. Clinicians should always follow the manufacturer’s user directions on what is specific to the air-powder polishing unit being used.

Unit preparation includes obtaining the necessary equipment, such as the air-powder polishing unit and abrasive powder, according to patient seating requirements.

The unit and handpiece nozzle is prepared according to manufacturer’s directions, and the powder compartment is filled with the appropriate abrasive recommended for the machine being used (Fig. 3). This should be turned on for at least 15 seconds to eliminate any residual powder or moisture in the lines. Also, water lines need to be flushed before use, because of the possibility of contamination of the Centers for Disease Control and Prevention. When the unit’s hoppers is being filled with abrasive powder, the unit must be turned off. It needs to be filled with water and air and on top of the center tube. The clinician can place a finger over the tube in the middle of the chamber to prevent powder from blocking the air line. Nitrous oxide being used must be controlled on top of the powder chamber unit and the clinical assistant according to the patient’s needs. For treating patients with heavy stains, it is recommended that the control on top of the powder chamber unit must be increased. For patients with heavy staining, the control knob will be set to “8” for reduced powder dose, which is approximately the 6 o’clock position (Fig. 4).

An aerosol-reduction device that contains the salivary-expector or high-speed-evacuation system used with the air-powder polisher has been shown to be effective in controlling and reducing air-powder aerosols, thus decreasing the potential for disease transmission. The aerosol-reduction device also reduces the possibility of aerosol contamination to the visible aerosol normally produced during procedures. Additionally, the aerosol-reduction device (Fig. 5) eliminates the need for exact measurements with the aerosol-reduction device, which is approximate for the 12 o’clock position. For patients with light staining, the control knob will be set to “5.”

**Fig. 1a** Removal of extrinsic stains. (Photo/Provided by Yossi Rotemzana, DDS, DENTISITY Professional)

**Fig. 1b** The powder chamber with an abrasive recommended by the manufacturer.

**Fig. 2** Powder control unit.

**Fig. 3** Air Fresh propoxy powder. (Photo/Provided DENTSPLY Professional unless otherwise noted)

**Fig. 4** Power control valve.

**Fig. 5** Sodium-free powder.
two teeth at a time will ensure that brush motion from interproximal circular motion, sweeping or paint evacuation. The nozzle tip also should be used at a consistent distance (approximately 3 to 4 mm). Hold the nozzle farther away from the teeth for any remaining stain. Thor Long.

Conclusions
Therapeutic polishing is the removal of stains from the unexposed root surfaces, which results in a decrease in disease parameters. Polishing root surfaces is possible with both the rubber-cup and air-powder polisher; however, the rationale for selecting the air-powder polisher is for its efficacy and efficiency.

The clinician should follow the precautions and considerations presented when polishing for therapeutic benefits with the air-powder polisher. The clinician should be aware to direct the air-powder spray against the tooth surface, not the exposed soft tissues. Most importantly the clinician must consider all options — esthetic, therapeutic and patient goals — when designing a treatment plan.

Contact Information
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References are available from the author.

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The patient assessment process should include mental health as risk factors for the use of intraoral cleaning devices for patients with sensitivity or allergy to nickel and/or are an intraoral physician-directed, colonized-restricted diet.

Clinical technique
There is a universal air-powder polishing technique that can be used with all types of systems, however manufacturers may have different instructions for use of their equipment.

The recommended technique prevents aerosol delivery from deflecting back to the clinician or being directed into the patient’s soft tissues. The use of high-speed evacuation or the aerosol-reduction device is the most efficient way to control the aerosol spray. While positioning of the patient and operator are essentially unchanged, direct vision and access become dramatically important as the powder is activated.

Positioning the patient slightly upright at 45 degrees with the patient’s head toward the operator to access areas — and reclining to treat maxillary posterior teeth — and repositioning the patient’s lip with the index finger to provide gentle pressure will ensure that all tooth surfaces are adequately be disposed of and the nozzle should be cleaned with a wire cleaning tool to prevent clogging. Nozzle tips must be autoclaved after each use, and the entire unit should be disinfected with an EPA-approved disinfectant. Using a disposable barrier will help minimize disinfecting time.

At the end of the workday, the nozzle should be turned off, powder removed from chamber and unused powder discarded to prevent clogging of lines. Also, keep the powder chamber and air lines free of moisture, which can cause the system to fail. The clinician then needs to remove any residual powder from the chamber with a HVE and autoclave the unit for approximately 15 seconds to clear any powder remaining in the chamber.

Fig. 7

The clinician must polish each tooth approximately one to two seconds, and to avoid loss of tooth structure, not subject any tooth to more than 10 seconds of air-powder slurry. Rest surfaces should be exposed to slurry for even less time or entirely avoided because they abrasively wear more rapidly than enamel.

The DENTSPLY Cavitron Jet Plus™ has Tip-On™ technology (Fig. 8) that automatically cycles between rinse and polish, thus eliminating the need for clinician to pump the pedal. Tapping the foot pedal once activates the Tip-On automatic air polishing/rinse cycle, which lasts for approximately one second. Tapping the pedal a second time disables the automatic air-polishing/rinse cycle.

The autocycles work in short, medium or long format (Fig. 7) within timed cycles of one minute. Each cycle begins with a two- to three-second stream of water. The “short” auticycle is 0.75 seconds of air-powder polishing followed by a 1.25-second rinse; the “medium” auticycle is two seconds of air-powder polishing followed by a one-second rinse; and the “long” auticycle is three seconds of air-powder polishing followed by a two-second rinse.

The “manual” cycle setting enables the clinician to use the Tip-On foot technology control to alternate manually between air-powder polishing and rinse.

When air-polishing the anterior teeth, the tip should be directed at a 60-degree angle to the tooth; for posterior teeth the angle should be 80 degrees; and for occlusal surfaces, a 90-degree angle is recommended. Using the aerosol reduction device, the clinician will apply the disposable cup (attached to the nozzle) to the middle third of the tooth with light pressure to flare the cup. The clinician will then repeat the procedure from the middle third of the tooth to more than 10 seconds of air-polishing, rinse.

When air-polishing the anterior teeth, the tip should be directed at a 60-degree angle to the tooth, for posterior teeth the angle should be 80 degrees; and for occlusal surfaces, a 90-degree angle is recommended. Using the aerosol reduction device, the clinician will apply the disposable cup (attached to the nozzle) to the middle third of the tooth with light pressure to flare the cup. The clinician will then repeat the procedure from the middle third of the tooth to more than 10 seconds of air-polishing, rinse.

Composition of air-polishing procedure
At completion of the air-polishing procedure, the clinician should rinse the teeth thoroughly, loll interproximal surfaces and inspect the teeth for any remaining stain. Thorough rinsing is essential after air-powder polishing because of the basic nature of the sodium bicarbonate.

If stain is still present, remineralization and/or use of the air-powder polisher may be indicated. Any debris should be wiped off the patient’s face with a moist towel. And a re-application of lip balm should be offered.

The aerosol-reduction device should...
show our worth to them, it was an outstanding task.

Give an example of an activity where you applied knowledge from previous coursework in a project to a work in another class.

What was the most difficult situation you have faced? When was the time you were working on the project for the earth week and had the solar week to prepare and release on the same day and it always shows better results.

Describe a situation in which you had to deal with the other students were not up to your professor’s or supervisor’s expectations. What happened? What did you do about it?

Tell me about a difficult situation you were working with someone who was difficult to get along with. Why was this person difficult? How did you handle that person?

Describe an activity where you had to work with someone who was difficult to get along with. Why was this person difficult? How did you handle that person?

It was our high profile person in the college, we had to deal with him and he used to take everything somehow in a negative way, so we met him to use him to use specific words before talk to him in that situation to avoid any kind of misunderstanding.

Give me an example of a specific activity that you did that helped build enthusiasm in others?

Our club is one of the example and every meeting we have a session for symposium and apply that with our dental students and we were successful from the last three years.

Describe a specific problem that you faced for your project. How did you approach the problem? What were the outcomes? How did it turn out?

It can sometimes be difficult to find just the right words to express our appreciation for those prominent distinguished students for their perseverance, challenge and success. The most glorious moments in our lives are not just the so-called days of success but rather those days when challenges rise in you with a promise of future accomplishments. The only way of finding the limits of the possible is by going beyond them to the impossible. Difficulties strengthen the mind and are challenging is inevitable but our ability to stand strong and adjust to the new ideas and face change. The gem cannot be polished without friction nor the man perfumed without trials. We would like to always remember that you are stronger than you believe, stronger than you seem and smarter than you think. It is our main target to take those innerved seeds and strengthen them with words of encouragement and appreciation that helping them succeed in the worlds of our work, practice, education and research.

Let me give you some words to know that you are always our focus and our target should be consistent with this life is gone.

Convince me that you can adapt to a wide variety of people, situations and customs?

Yes we can adapt because it’s the attitude and enthusiasm that works more over the years.

When it was desirable for you to keep a positive attitude, how did you do it?

We always try to show the people how productive we are by giving public lecture on oral hygiene.

When you were working on the project for the earth week and had the solar week to prepare and release on the same day and it always shows better results.

When it was desirable for you to keep a positive attitude, how did you do it?

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When you were working on the project for the earth week and had the solar week to prepare and release on the same day and it always shows better results.
New Methods In Conservaive Periodontitis Treatment

The following case study illustrates the effectiveness of a treatment concept for the decontamination of root surfaces colonized with subgingival biofilm using low-abrasion powder jet technology. The aim of this case study was to evaluate the clinical and microbiological results during conservative periodontitis therapy using a low-abrasion subgingival air polishing system (AIR-N-GO PERIO®).

By Prof. Dr. Wolf-Dieter Grimm

Periodontal diseases, as established by the ground-breaking investigations of Loe et al. (1968) and Fregin (1969), film and minimizing the periodontal disease at its inception, is characterized by destruction of the periodontal tissues, including the periodontal ligament, the root cementum, the alveolar bone and the gingiva (see Fig. 1). Marginal periodontitis is an opportunistic infection (Fig. 2) which is caused by a gram negative, anaerobic, range of bacteria and is resulting in a chronic inflammation of the periodontal tissues (Socransky and Haf- faz 1992).

The progressive loss of periodontal tissue and attachment can be observed in the course of the periodontal inflammation.

Based on epidemiological studies (Fig. 2 and reference of chronic marginal periodontitis in the population over the age of 35 years in Germany is approx. 40-45%, while approx. 35% of this age group suffers from a moderate to severe (approx. 25%) form of periodontitis. It has also been possible, however, to observe moderately severe (approx. 15%) and severe (approx. 5%) forms of periodontal disease in industrialized countries. In the case of older people (seniors), almost one in two exhibits inflammatory-destructive changes (moderate-severe/severe) of the periodontium (DAS, 2006).

Conservative therapy can prevent the disease from progressing (Santarosa et al. 2004). Therefore the mechanical supragingival and subgingival removal of calculus and plaque is medicated by tooth brushing and mouth rinsing. A good oral hygiene is crucial for periodontitis patients.

The primary objective of conservative periodontal therapy which is a result of less than adequate ability to clean the root surfaces. There was also the risk of causing caries. The AIR-N-GO PERIO® system replaces the insoluble sodium bicarbonate powder with soluble sodium bicarbonate powder which has a less abrasive power. Moreover, in clinical studies (reference literature at www.aeroimg- concept.com), it could be demonstrated that the powder exerts no adverse effects on the surrounding soft tissues due to its air polishing process. The AIR-N-GO PERIO® instrument, with its subgingival attachment and its system for the air polishing (Fig. 3) developed specifically for working with the subgingival pocket, is the result of cutting-edge CFD technology (numerical flow technology).

The adjacent anatomical structures are not irritated and thorough removal of the subgingival biofilm on the root surface reduces marginal inflammation. The initial results presented are part of a clinically and microbiologically controlled and randomized long-term study in order to compare the clinical effectiveness of low-abrasion air-sinusoidal-assisted air polishing systems (microbiological investigations only), after six weeks and after three months (Tab. 1).

After the preparative treatment had been carried out successfully and the patients had been given a written and verbal explanation, those included in the study after an informed consent and written declaration in accordance with the Helsinki Decla- ration (following amendment of the 4th World Medical Assembly, Hong Kong, September 1989).

Preparative treatment

All patients were involved in preparative treatment following the initial examination. The patients received oral mechanical hygiene instructions and professional supragingival debridement as necessary. The clinical and microbiological parameters were recorded before starting, immediately after intervention (microbiological investigations only), after six weeks and after three months (Tab. 1).

The results for subgingival biofilm using the AIR-N-GO SUPRA (Fig. 4). The six polisher wands with a minuscule jet of air, water and an abrasive is a cleaning powder that has been specially developed to be minimally traumatic to deliniate molar tissue. The powder's rounded microstructure, and the fineness of the calcium carbonate-based micro-beads protect the tooth structure, as well as the stable and effective cleaning of the tooth surfaces. The powder also reaches difficult areas such as tight interproximal spaces.

Clinical parameters

The clinical attachment level (CAL), bleeding on probing (BOP), probing depth (PD) and gingival recession (GR) were determined and evaluated descriptively. The Wilcoxon signed- rank test was used to compare the original data with the findings after application of the low-abrasion, sinusoidal-assisted air polishing system. The statistical tests were carried out using the SPSS statistics program.

Results

Demographic data

All the patients in the investigation (n = 15) remained in the study for the entire observation period of three months; there was no change in the number of patients. 56.6% of the patients received females and 43.4% were male. The age of the study was 35.7%. All the patients gave their written consent in accordance with the study protocol.

Statistical evaluation

When the investigations were complete, a comparison of the variables clinical attachment level (CAL), bleeding on probing (BOP), probing depth (PD) and gingival recession (GR), were determined and evaluated descriptively. The Wilcoxon signed-rank test was used to compare the original data with the findings after application of the low-abrasion, sinusoidal-assisted air polishing system. The statistical tests were carried out using the SPSS statistics program.

Table 1: Mean value and standard deviation of the PD and CAL values for the base line study six weeks post-operative and three months post-operative

<table>
<thead>
<tr>
<th>Variable</th>
<th>Base line (BL)</th>
<th>6 WEEKS (AFT6WKS)</th>
<th>3 months (AFT3WKS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD (mm)</td>
<td>4.14 ± 0.52</td>
<td>3.84 ± 0.49</td>
<td>3.81 ± 0.41</td>
</tr>
<tr>
<td>BOP (%)</td>
<td>0.68 ± 0.49</td>
<td>0.34 ± 0.27</td>
<td>0.36 ± 0.18</td>
</tr>
<tr>
<td>CAL (mm)</td>
<td>6.07 ± 0.60</td>
<td>5.97 ± 0.68</td>
<td>5.87 ± 0.58</td>
</tr>
</tbody>
</table>

Table 2: Mean value and standard deviation of the PD and CAL values for the base line study six weeks post-operative and after three months for all periodontitis and for areas on the microbiological study tooth at an infection of 2.13 ± 0.04 mm (reduction in the probing depth of 1.34 ± 0.03 mm). Table 3: Mean value and standard deviation of the BOP and GR for all the investigation periods. In the AIR-N-GO PERIO group, the increase in the BOP (compared to the original findings) after six and three months was statistically significant (p<0.01). The slight increase in the GR compared to the original findings reflects the improved inflammatory situation of the gingiva compared to the AIR-N-GO PERIO therapy.

Microbiological results

The results for subgingival marker bacteria A. actinomycescens, P. gingivalis ( Pg), T. denticola (Td) and, in addition, the total number of marker bacteria (TRB) were recorded, the results in each case are given in millions pathogens per ml of subgingival fluid. The microbiological results are summarized in Table 4. An exhibit- ted the lowest concentration (0.05 x 10^6) pre-operatively at the time base line of all the species investigated. Five weeks after treatment, the concentra- tion of these bacteria was elevated again and three months post-operatively it had almost reached the original valu-
Current Concepts On Improving Sealants Retention

By Katerina Kevadou DDS, MS, P{D} Associate Professor and Director of the Graduate Periodontal Education in European University College Dubai - UAE

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Research

12

Dental sealants have been recognized in an effective approach for the prevention of pit and fissure caries in primary and permanent teeth. The children are placed to prevent caries initiation and to arrest caries progression by providing a physical barrier that inhibits microorganisms and food particles from colonizing in pits and fissures. It is generally accepted that the effectiveness of sealants for caries prevention depends on their long-term retention. What follows is examining the factors which influence sealants prior to application, contributing better to the sealant retention.

It has been long known that remova- l of the superfluous plaque material is essential prior to etching in order to allow bonding of the sealant. The classic technique for removing of the debris prior to sealing is prophylaxis with a non-flu- oridated toothpaste, new techniques however have emerged, such as air-powder, air abrasion techniques. Air-polishing technique with sodium bicarbonate is an irreversible removal of organic and other elements from pit and fissure areas with the depth of the sealant resin penetration and when combined with acid etching produce higher mean bond strength.

Although it is recommen- ded, never became the standard for sealant application procedure due to equipment cost and complexity of the procedure. Air abrasion with aluminum oxide particles is another alternative for cleaning of the fissures, and also produces roughening of the enamel surface. However is a substitute to acid etching and appears to be inferior to the acid-etch tech- nique for use in public health settings.

When both techniques of air abrasi- on and polishing are used, simi- lar bond strength have been found greater than when enamel is only air-abraded and then acid-etched. Enameloplasty or reshaping of en-amel, is indicated in deep fissures and narrow fissures to improve of, to increase the fissure width and surface area available for etching and to enhance the accuracy of visual ex- amination. Studies have shown with this technique that caries-generating and gaps being evident and less microleakage, however its disadvantages are higher polymerisation shrinkage and a necessary removal of intact enamel for complete etching.

Does the use of a bonding agent prior to sealant application influence its retention?

Results from an in vitro study, in- et revealed that the use of a bonding agent after etching and pri- vor sealant application since micro- cule was found even in the case of contaminated with saliva enamel. However results from in vivo stu- dies, found no statistical significant difference in sealant retention for up to two years follow up. Of the use a bonding agent before sealant application is required to control the American Academy of Pediatric Dentistry. Dentistry, primarily in deep and early carious lesions, since data from in vit- o studies support that there is deeper penetration in deep fissures or carious enamel after its use.

What type of sealant material has the highest retention rate?

Two types of sealant materials are the most commonly-used, the resin-based and the glass ionomer sealants. Resin- based sealants exhibit the highest re- tention rates and have better stability under occlusal forces due to their main component. Bis-ACM. How- ever teeth sealed with glass ionomers develop caries less frequently than those sealed with resin and this has been attributed to the fluoride release from the glass ionomer cement. Even more, if the glass ionomer sealant is lost, some of the material remains in the depth of the fissures providing ex- tra preventive effect.

How successful are sealants over the years? What problems do you expect to occur?

Data on 200 patients after 15 years with autopolymerised sealants on permanent first molars, showed only partly re- placement retention in 40% of the teeth while 60% had partial retention. Car- iox or restored surfaces were found in 31% of sealed teeth and 83% of the unrestored. Regarding the surfaces sealed, retention was lower in pits or fissures of Carabelli’s cusps of maxil- lary molars. Caries experience was lower under partially retained sealants or missing sealants (4.5%) and com- pletely retained (0.4%), as compared to the teeth that were never sealed.

This was analyzed during di- using ATP measurement immediately after intervention. Only A. actinomy- cetemcomitans, T. forsythensis and c. rectus were detected, never became the standard for caries prevention. Nevertheless, the prevalence of the species decreased (3%). In the third month post- operatively increased again only slightly (16.6%) with an incidence of 60% after three months. T. forsythensis, which are the most difficult to control, was present in 85% of bacteria, not the required elimination for the base line investigation. These results therefore almost completely reconstitute the periodontal retention of the examined patients.

The similarity high percentages of pe- cts in which the species of the “red complex” (Pg, Tt, Td, Aa) were detected was striking. Pg and Tt colonized 77.2% of all pixels prior to treatment, the presence of Aa in the complex became lower immediately after intervention (33.5%) and rose noticeably (47.2%). At each point in the in- vestigation, most of the pixels pre- sented a combination of four bacteria (35.1% of pixels pre-operatively) and 20.8% and 28.0% of pixels mod- erately after intervention and after six weeks irrespective of the type of therapy used. The proportion of po- ites with only one species bacteria increased in the third month.

Does placing sealants over early caries influence their retention rates and have better stability under occlusal forces due to their main component. Bis-ACM. However teeth sealed with glass ionomers develop caries less frequently than those sealed with resin and this has been attributed to the fluoride release from the glass ionomer cement. Even more, if the glass ionomer sealant is lost, some of the material remains in the depth of the fissures providing extra preventive effect. Sealants can be repaired in a perfect manner, by removing the superficial plaque material and etching. Replacing the sealant material and in 20% of pockets immediately after sealant placement, compared with unsealed teeth 11. Beauchamp. J Caufield P, Crall J, Dony D, Kuffel F, Grosch B, Israil A, Kohn W, Siegel M, Simonson R. Evidence-Based clinical recommendations for the use of pit-and-fissure sealants. JADA 2008; 139(1):257-268. Oong E, Griffin S, John K, Woh B, Pages W, Caufield C. The efficiency of sealants in managing caries lesions JADA 2008; 139(1): 271 - 278. Simonson R, Osmon D, Freckon J, Brokholm E, Traus L. Microleakage and sealant penetration in primary and permanent teeth. J Dent 2007; 9: 9 - 14. Osmon D, Osmon M, Osland C, Langeland D. Microleakage of three different on second sound layer. sealant material and lining curing. sealant material and lining curing. sealant. sealant material and lining curing. sealant material and lining curing. sealant material and lining curing.

Sealants can be repaired in a perfect manner, by removing the superficial plaque material and etching. Replacing the sealant material and in 20% of pockets immediately after sealant placement, compared with unsealed teeth. Results of a sys- tematic review on the effect of sealants on caries in bacteriology, acid etching, replacing the sealant material and lining curing. Sealing planes placing over early car- iox lesions, influence their reten- tion rate.

Placement of pit and fissure sealants significantly reduces the percentage of non-cariated carious lesions that progress in children, adolescents, young adults for as long as five years after sealant placement, compared with unsealed teeth. Results of a sys- tematic review on the effect of sealants on caries in bacteriology, acid etching, replacing the sealant material and lining curing.

References

6. Meijer J, Mijer J: Glass-ionomer and resin-based fissure sealants: a clinical and microbiological study. J Dent 2007; 35:345-350. Fur- tness. The effect on the obligatory patho- genic bacteria such as Actinobacillus actinomycetemcomitans, Porphyro- monas gingivalis and T. forsythensis, which are the most difficult to control, is very promising. How- ever, this does not mean that another bacteria, not the required elimination for the base line investigation. The results allow one to conclude that a better long-term outcome can be achieved after clinical periodontal therapy using the low-abrasion, so- matically modified glass ionomer (AIR-N-GO PERIOD).
Now In The UAE

Since 1995 Middle East Dental Laboratory has been a vanguard of the latest advancements in the field of dental technology in the UAE; and gained a reputation for expertise in the fields of orthodontics implants and cosmetic dentistry.

Now with the support of a state-of-the-art full service laboratory, dental suites and skilled technicians our expanded facility is able to offer Inman Aligners—an innovation in front teeth alignment. The Inman Aligner is a simple removable appliance used to align front teeth quickly and safely. It's ideal as a stand alone treatment or to pre-align teeth prior to further cosmetic options such as bonding or minimal veneers.

How does it work?

The Inman Aligner has Nickel Titanium coil springs that power two aligner bows that gently oppose each other, guiding the teeth into their new position. These gentle forces are active over a very large range of movement, which is why the Inman Aligner works so quickly. The image (Fig. 1) shows the squeeze effect of the two aligner bows on the front teeth. The inner bow pushes forwards, while the outer bow pulls back on the front teeth.

As the leading dental laboratory in the Middle East, we work within international guidelines to deliver this latest advancement in the field of dental technology. Our experienced staff offer a hopskotch service for optimal results.

The first course in Dubai to become an accredited Inman Aligner doctor is being held on November 10th and 11th 2013. Check the website for more course information and other upcoming training dates & events.

Fig. 1. The squeeze effect of the two aligner bows on the front teeth.

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IDEM Singapore offers an interactive trade article app for the iPad. This app allows users to easily and conveniently navigate clinical case reports. In the current edition of this digital publication, Jan Kurtz-Hoffmann, dentist, and Frank Zalich, dental technician, provide detailed insight into the treatment of a very complex case.

Ivoclar Vivadent is now offering the trade article from Reflect Magazine 2/2013 entitled “When concepts intertwine” by Jan Kurtz-Hoffmann and Frank Zalich also in digital form (app). In this article, the authors give an account of the replacement of prosthesis restorations in a patient using the IPS e.max system from Ivoclar Vivadent. They show that achieving a functional, esthetic result in such a complex case depends on the interplay of many individual disciplines stretching from surgery, implantology, periodontology and endodontics through to prosthetics and dental technology.

In the digital version of this article, the entire treatment procedure is shown – from treatment planning to seating of the final restoration. Users of this app benefit from extensive photo sequences. Moreover, they can obtain information about the products used and learn more about the authors. A digital app version is published three times a year in the languages German, English, French, Italian and Spanish. Apart from the current case, two further cases are available in digital form.

Scan the QR code with your iPad or enter the following link: http://www.ivoclarvivadent.com/reflect

Interactive Trade Article Reading Experience

By Ivoclar Vivadent
Dental Treatments Get Hi-Tec

FKG Dentaire SA, La Chaux de Fonds (Switzerland), is pleased to announce the global launch of the Rooter, a new motor for endodontic treatments - also known as Root Canal Treatments. Engineers innovated in every step of the creation process, all designed to improve patient comfort and functionality for the dentist. The end result? A more agreeable experience for the patient!

Endodontic treatments are rarely a pleasant process, even if modern tools and processes are conceived to reduce patient discomfort. The Rooter from FKG DENTAIRE also focuses on dentist and endodontist usability.

“We are responding to specialists’ requests and expectations by making complex interventions easier, thanks to a range of innovative functions,” says Thierry Rouiller, CEO of FKG Dentaire. “For example, pre-programmed memory locations, greater freedom of movement thanks to our wireless technology, a particularly ergonomic tool and even a LED light to improve operational visibility all give our new Rooter motor real innovative advances.”

This high technology precision will be distributed from April in more than 80 countries, flying the flag for La Chaux-de-Fonds innovation, perfection and reliability across the world.

Selected technical details
- Powerful white LED light focused on the work zone
- Wide range of speeds - from 250 to 1200 rpm
- 10 programmable memory locations, of which 3 pre-programmed in our factory
- 360° orientation in 5 positions
- Disengage autoreverse mode
- Wireless tool, with Li-Ion battery to ensure stable rotation speed
- 10 preritable torque/speed programmes
The American Academy of Implant Dentistry Proudly Presents the 2nd Global Conference in Dubai

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Dr. Rafael García ESP E J O (Spain)

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Dr. Dalia EL BOK L E (Egypt)
Dr. Roland KM E I D (France)
Dr. Bader Eddin BORGAN (Jordan)

New Delhi in 2010 along with their peers. Graduate residents and Academia will proudly be dis- playing their research through poster presentations.

A half mark of this congress will be post-conference hands-on Advanced bone grafting course which will fea- ture a separate hard tissue and soft tissue augmentation programs. This is a limited participation program that will be a pre-requisite course for the live patient training program later in the year.

I am pleased to invite you to this con- ference to witness some of the finest in the field and be immersed with the fusion of orthopedic and implant den- tistry. I am sure you will bring back comfort and warmth and friendliness that will entice you to be.

I hope to personally greet you at the congress and welcome you to be part of our international community. You will find an atmosphere of camarade- rie, warmth and friendliness that will entice you to be.

SPEAKERS:
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Dr. John W. GRAHAM (USA)
Dr. Nasir AL HAML AN (KSA)
Dr. Faraj BEHRESHANI (Kuwait)
Dr. Claudio R. L EMASSI ONI (France)
Dr. Khraisat SAMI ABOULAZIM (Egypt)
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Shankar Iyer DDS, MDS
Conference Chairman
Secretary, AAID
Global Chair, AAID

What Happens In Dubai Does Not Have To Stay In Dubai

The American Academy of Implant Dentistry Proudly Presents the 2nd Global Conference in Dubai

By Shankar Iyer

The first Global conference of the AAID was held in New Delhi in 2010 along with the World Congress of Oral Implantology and this time the second Global conference is being held with the 5th Annual Dental Fe- cial Conference. The theme of the Conference is "Provocative Issues in Implant Dentistry". World renom- nied experts will present the state of the art concepts to explore the cont- lusions surrounding dental implant therapy. What type of soft tissue aug- mentation works? Which is the best method to grow bone vertically? Is "All on Four" better than traditio- nal hybrid prosthesis? Protocols to manage periimplantitis and several other issues will be presented at this conference.

I am delighted to work with Dr. Nio- nnette Bandy who is the Secretary for the conger and has made some signi- ficant strides in educating AAID Ma- nicipercipants in the UAE. We are bringing world class speakers like Drs. Michael Schneck, Hilt Tatum, Na- talie Wong, Mark Lin to name a few. In addition to the main congress ex- pert clinicians will present table cli- nics to share their tips and techniques with their peers. Graduate residents and Academia will proudly be dis- playing their research through poster presentations.

A half mark of this congress will be post-conference hands-on Advanced bone grafting course which will fea- ture a separate hard tissue and soft tissue augmentation programs. This is a limited participation program that will be a pre-requisite course for the live patient training program later in the year.

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And others interested in the field of implant dentistry come a memory. You organization, we currently represent over 4,500 dentists worldwide.

The American Academy of Implant Dentistry (AAID) stands for excel- lence in education, scientific develop- ment and patient care. Members who demonstrate the highest standards in implantology find the AAID to be the organization which supports their clinical and research interests, as well as recognition for their achievements.

The Academy’s mission is simple: To advance the science and practice of implant dentistry through education, research support and to serve as the credentialing standard for implant dentistry for the benefit of mankind.

AAID stands for excellence in edu- cation, scientific development and patient care. The Academy provides bona fide credentialing in implant dentistry through the Associate Fellow and Fellow examinations. The Associate Fellow and Fellow credentials are recognized by numerous state boards.

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Dr. Jose Navarro  
Dr. Philippe Russe  
Dr. Stavros Pelekanos  
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- € 3,500 prior to the second session
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3. Beverly Hills Formula whitening toothpaste has been in the oral health and beauty sector for over 20 years. Where do you think its success lies?

Combining leading scientific advancements and the finest ingredients from both health and beauty industries, Beverly Hills Formula has developed its whitening toothpaste since 1992. All ingredients are sourced from the finest quality waters of Co. Wicklow, Ireland. We are committed to using only the best ingredients and the finest ingredients that were responsible for tooth sensitivity. To ensure a gentle and effective whitening process, Beverly Hills Formula developed a unique whitening toothpaste that contains a low abrasion, desensitising, and pain-relieving agent that helps to alleviate tooth sensitivity.

4. What are your views on professional tooth whitening? And how can your products support this treatment?

Beverly Hills Formula is proud to present the latest advancement in the tooth whitening industry by combining extensive scientific knowledge from across Europe and particularly in the UK withArm & Hammer's advanced whitening technology. Approaching the whitening market from a scientific perspective, Beverly Hills Formula has developed a range of whitening toothpastes that contain high levels of calcium, with the highest levels found in the European market. The Beverly Hills Formula whitening toothpaste range has been designed to provide a comprehensive range of whitening options for all individuals.

5. With an array of tooth whitening products on the shelves, what makes your whitening toothpaste stand out from the crowd?

Beverly Hills Formula Natural Whitening Expert toothpaste proved more effective at removing stains when compared with other leading brands of whitening toothpastes and toothpastes, with over 95% of stains removed over a five-minute period (3).

6. Sensitivity is a common problem, especially after professional tooth whitening. Is there anything dentists can do to help alleviate this discomfort for patients?

A 2012 USA-based independent testing laboratory 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 whitening toothpaste. In fact, Beverly Hills Formula Total White toothpaste was tested to have a relative dentin abrasivity (RDA) value of 0.43, which is significantly lower than other leading brands. This desensitising agent relieves tooth sensitivity by effectively blocking the transmission of pain sensation between the nerve cells that enable cold and hot sensations to reach the tooth’s surface. Those who require extra sensitivity relief can benefit from the Whitening Paste, a great record of attendance and continued support.

7. There has been some speculation that whitening toothpastes aren’t effective. Is this true?

Unfortunately, 2012 saw whitening toothpastes come under scrutiny in Europe and particularly in the UK when Ann & Hammer’s Advanced Whitening toothpaste advertisements were banned after it emerged that 46% of users, during one-week trial, either saw no improvement or were left with darker teeth (2). By association, many dental professionals and patients assume that all whitening toothpastes do not live up to these claims. This is not true! Contrary to this, it’s important that toothpastes, which safely and effectively whiten and are proven to work, are brought to you by your patients’ attention. In 2012 a UK Dental School performed an independent laboratory study its aim was to measure stain removal in order to discover how effective various toothpastes were at removing dietary stains from Picnic Food and stains. The laboratory tests revealed that stain removal was performed after just one minute. Of the products tested, Beverly Hills Formula...
**Laser-Lok Technology**

**BioHorizons**

**Captions**

1. Implant success rate is the weighted average of all published human studies on BioHorizons implants. These studies are available for review in this document and BioHorizons document number ML0130.


**Contact Information**

BioHorizons
Greg Bryant
205-986-7894 (USA)
Director, Communication & Education

**Images and Cartoons**

Colorized SEM of a dental implant harvested at 6 months post-ops shows the connective tissue is physically attached and interdigitated with the laser-Lok surface.

Human histology shows the apical extent of the junctional epithelium below which there is a supranormal connective tissue attachment to the laser-Lok surface.

Polared lights show the connective tissue is functionally oriented.

**Laser-Lok overview**

Laser-Lok microchannels is a proprietary dental implant surface treatment developed from over 20 years of research initiated to create the optimal implant surface. Through this research, the unique Laser-Lok surface has been shown to elicit a biologic response that includes the inhibition of epithelial cell growth, and maximizes the cells ability to osseointegrate into bone. This physical attachment produces a biologic seal around the implant that prevents and minimizes crestal bone health. The Laser-Lok phenomenon has been shown in post-market studies to be more effective than other implant designs in reducing bone loss.

**Unique surface characteristics**

Laser-Lok microchannels is a series of cell-sized circumferential channels that are precisely created using laser ablation technology. This technology produces extremely consistent microchannels that are optimally sized to attract and organize both osteoblasts and fibroblasts. The Laser-Lok microstructure also includes a repeating nanostructure that maximizes surface area and enables cell pseudopodia and collagen microfibrils to interdigitate with the Laser-Lok surface.

**The clinical advantage**

The Laser-Lok surface has been shown in several studies to offer a clinical advantage over other implant designs. In a prospective, controlled multi-center study, Laser-Lok implants, when placed alongside identical implants with a traditional surface, were shown at 37 months post-op to reduce bone loss by 70% (or 1.15mm)4. In a retrospective, private practice study, Laser-Lok implants placed in a variety of site conditions and followed up to 3 years minimized bone loss to 0.46mm.5 In a prospective, University-based overdenture study, Laser-Lok implants reduced bone loss by 63% versus Non-belReplace Select.6,7

**References**

- [BioHorizons](http://www.biohorizons.com)
- [Contact Information](http://www.biohorizons.com/contact)

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Colorized SEM of a dental implant harvested at 6 months post-ops shows the connective tissue is physically attached and interdigitated with the laser-Lok surfaces.

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ASIA PACIFIC SYMPOSIUM SERIES 2013

Shangri-La Hotel
September 6-8, 2013
Mumbai, India

FEATURING
Marius Steigmann
Bach Le
Jack Ricci
Alain Romanos

REGISTRATION
Zhou Liang
zliang@biohorizons.com
+1-205-986-7918
Eminent Polish pianist, Piotr Folkert who is known for his sensitivity and depth of interpretation did not disappoint when he came to perform a demanding recital at concert series, “Music Under The Stars of Dubai”. His playing during Bach-Liszt Organ Prelude and Fugue in A Minor BWV 543 revealed a strong awareness of structure, thoughtfully supported by rich and elegant vocal lines. You could not fail to be carried away by the monumental flow of his contrapuntal music making, which culminated in the evening’s highlight of the four Chopin Ballades. Mr Folkert’s concentration was penetrating as he performed some of the most demanding pieces in the piano repertoire. His refined touch enabled him to display both great dynamic range and subtle shading throughout each piece, illuminating the poetic strength, profundity and grace of Chopin’s wondrous narratives.

On this balmy night in a leafy salon hideaway neighbouring the famous Burj Al Arab, German impresario Manfred Mumedey has created a unique event that brings the highest musical calibre and culture to the city of Dubai. He is indeed taking a further step through these prestigious concerts to launch the United Arab Emirates Young Artist Foundation in order to support emerging talent within the region. We were therefore most fortunate to witness piano recitals from Mr Folkert’s gifted daughters, Eliza, 12 and Emilia, 11, young artists following confidently in their father’s footsteps. Emilia played first. There was a strong rhythmic pulse to her music making as she ably inhabited the different worlds of Beethoven’s “Nel Cor Piu Non Mi Sento” 6 Variations in G major bringing out their charm and grace. Emilia’s pianistic skill meant she could easily convey the contrasting moods of each piece, switching easily between bright and happy moods, to the demands of a more muscular and emphatic sound. Emilia’s strong connection to the music of Polish pianist, Boleslaw Woytowicz Capriccio (1948) was clearly palpable. She brought a mature coherence to the percussive sounds, extensive runs and angular harmonies within the modern piece, causing her strong musical personality to shine through every note.

Eliza followed her younger sister on stage and as the first crystal clear tone of Chopin’s Étude in F Minor op. 25 #2 cut through the night air, it was clear that we had a focused, intuitive artist before our eyes. Her strong fingers were again evident as she produced a committed and even sound during the performance of Chopin’s Étude in C minor op. 25 #12. Throughout each piece Eliza possessed an immaculate, sparkling technique that allowed the music to breathe and gave it sensitivity and heart. Her sense of detail and exploration became more evident during the Impromptus No. 1 in A flat Major op. 29, as we began to realize that musically, she is totally at home with the endless pianistic invention and abundance created by Chopin. After numerous rounds of applause for this sumptuous musical family affair, our source could not have ended on a more perfect note, as traditional Arabic food was served in perfect harmony with the red and white wines from regions of the world; a soothing accompaniment to the soft ebb and flow of animated conversation lasting long into the night.
REDUCES AND HELPS PREVENT GUM PROBLEMS IN 4 WEEKS TO ESCAPE THE CYCLE OF GINGIVITIS

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THE STARS IN DIGITAL DENTISTRY
Scientific Session - Sneak Preview

Friday 04 October 2013

Dr. Eduardo Mahn, Chile
> Pursuing Maximum Esthetics and Simplicity for Everyone with Modern CAD/CAM Materials

Dr. med. dent Andreas Bindl, Switzerland
> Clinical Applications of CAD/CAM Chairside Dentistry

Dr. Nicolas Boutin, France & Dr. Bernard Cannas, France
> "Contribution of 3D imaging and CAD/CAM to guided surgery immediate implant placement and immediate loading."

Dr. Bernd v/d Heyd & Werner Gosch, MDT, Germany
> "Performance is our Passion" A survey on CAD/CAM today towards the traditional craftsmanship

Dr. Philippe Tardieu, France
> The new world of images in dentistry and implantology

Morten Ryde, Denmark
> Decoding Digital Impression Taking

Ralf Oppacher, MDT, Germany
> The Bridge in the Digital Future! How do we combine Dentistry and Dental Technology?

Dr. Khaled Abouseada, Egypt & KSA
> What about CAD/CAM in Orthodontics?

Saturday 05 October 2013

Dr. med. Dr. med dent Lutz Ritter, Germany
> Taking guided Implantology to the next level: Integrating CAD/CAM and CBCT

Dr. Kurt Dawirs, DMD, DD, Germany
> A Complete 3-D Realization - From Virtual Planning to Final Individual Designed Prosthetics

Dr. Eduardo Mahn, Chile
> Predictable Preparation and Cementation Protocols for CAD/CAM Restorations

Joachim A. Maier, MDT, Germany
> ZOLID: Base for Aesthetic All-Ceramic with Long-Term Success

Prof. Dr. TaeWeon Kim, DDS, PhD, South Korea
> 3D Digital Aligners

Prof. Dr. TaeWeon Kim
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Simon Docker, United Kingdom
> CAD/CAM Technology for the Digital World

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SUNDAY 05 OCTOBER 2013
DENTAL TECHNICIANS PARALLEL SESSION

Pitsnu Intoratat
Thailand
Lithium Disilicate
Bridge - A "Long" Story, Made Simple

Rik Jacobs
The Netherlands
Biocompatible materials for 3D printing of dental technical jobs for the denture department of laboratories. What's Next? This is Next!!

Carsten Kelm
Australia
inLab, "The digital solution for your Lab"

Barış Çakır
Germany
Range of Applications with Translucent Zirconia

Ralph Oppacher
Germany
Shera The Bridge in the do we combine Dentistry and Dental Technology?
1 denture

4 cups of coffee

52 conversations

1 good day

1 cleansing tablet

**Corega daily denture cleanser**

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- Reduces plaque and stain build up*
- Simple daily cleansing solution for your patient’s dentures

*When used as directed. **

1. GSK Data on file. Micro study, MD# 060-03. SGDC/GIPOLD/0031/12 Prepared May 2012.

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