Weightlifter grits his teeth – a case for VITA ENAMIC

By Hermann Loos

Stress and high demands literally make us grit our teeth. On a colleague's homepage it says on the subject of teeth grinding and bruxism: “We can develop a weightlifter's strength just by using our teeth”. The masticatory organ is exposed to forces of up to 800 newtons during teeth clenching. The normal pressure of mastication is generally around 20 - 30 newtons. Those affected are often people in certain professions, for example, those who work for long periods of time on the computer, as well as those whose work involves intensive physical exertion, like runners, cyclists, bodybuilders and, as previously mentioned, weightlifters.

During subconscious clenching of the upper and lower teeth, the limit of physiological function is far exceeded. Not only natural tooth substance, however, but also restorative materials reach their limit during mechanical overload. In the clinical case example described here, this led to the fracture of an old all-ceramic crown restoration.

Patient case

The patient was a weightlifter by profession. He sought treatment for a fracture on the vestibular wall of his all-ceramic crown on tooth 25 (Fig. 1). He wanted a new, metal-free restoration. For the sake of time efficiency, treatment was planned with the CEREC chairside system.

The material of choice

A suitable material in this case was the new VITA ENAMIC, whose material composition and mechanical and physical properties offer a combination of ceramic and composite. The hybrid ceramic is a completely new generation of ceramic materials. The unique, dual network structure consists of a dominant ceramic network reinforced by a polymer network.

This follows the principle of compound materials, i.e. both networks penetrate each other mutually. Thus immense stability as well as extraordinary elasticity are guaranteed for the first time. In addition to classic, single tooth restorations (inlays, onlays, veneers and crowns), VITA ENAMIC’s range of indications includes minimally invasive restorations and restorations exposed to high masticatory forces. VITA ENAMIC is available in the geometry (size) EM-14 (12 x 14 x 18 mm) and in the translucency levels HT (High Translucency) and T (Translucent) and in five VITA SYSTEM 3D-MASTER shades 0M1, 1M1, 1M2, 2M2 and 3M2. VITA ENAMIC can be processed with Sirona's CEREC or inLab MC XL systems, software version 4.0 or higher.

The treatment procedure

After removing the fractured crown, further preparation suitable for ceramic was carried out on tooth 25 (Fig. 2). The digital impression (Fig. 3) was performed using the CEREC AC acquisition unit and the Bluecam. The CEREC 3D-software’s automatic biogenetic tooth modelling function was used for designing the crown restoration (Fig. 4). Occlusion registration was performed. The opposing jaw was not scanned. The biogenetic reconstruction of the occlusal surfaces is based on a mathematical procedure that allows the automatic reconstruction of the patient’s individual tooth morphology based on the morphology of the patient's re...

VITA ENAMIC® redefines load capacity.*

The first hybrid ceramic with dual network structure for unsurpassed absorption of masticatory forces

Fig. 1: Initial situation – fracture of the all-ceramic crown on tooth 25.

Fig. 2: Preparation.

Fig. 3: The digital model.

Fig. 4: Design.

Fig. 5 a: Different views of the crown after completion of the design ...

Fig. 5 b: ...in the milling preview.

The formula for success: strength + elasticity = reliability²

*) In addition to a high degree of elasticity, this innovative hybrid ceramic guarantees particularly high strength after adhesive bonding.

10 NEWS
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To learn more, visit ADA.org/meeting
remaining natural dentition. We obtained very good results using the 3D-software to adjust the occlusion of posterior crowns with the aid of the centric bite registration function and the automatic adaptation of the crowns’ occlusion with the antagonists. When required, manual corrections can, be made by the user at any time. Figures 5 a and 5b show the crown in the milling preview after completion of the design. According to the results obtained in situ (shade of prepared tooth 4L2,5 / tooth shade 3M2), a block in the shade 3M2 was chosen for the manufacture of the crown.

The VITA ENAMIC Polishing Set and the VITA ENAMIC STAINS KIT are available for reworking chairside manufactured VITA ENAMIC restorations. The polishing set includes a total of eight polishers for the handpiece, four for prepolishing and four for high-glaze polishing. A staining set is also available. Beside six stains, this also includes VITA ENAMIC Glaze for sealing the surface. The stains and the glaze are light-curing and very easy to process. The definitive intraoral cementation of the marginally accurate crown (Figs. 6 and 7) was performed with Multilink Automix (Ivoclar Vivadent), since VITA ENAMIC has a high loading capacity after adhesive bonding with the residual natural dentition.

Material benefits
Experience shows that the new VITA ENAMIC blocks can be milled very quickly from the digital design. This ensures milling results with high precision, edge

Cleanic®
Clinical use of a recognised prophy paste with Perlite

Cleanic® prophy paste by Kerr has a creamy and smooth consistency. It also has a pleasant fresh taste that is not too strong and is well accepted by the patient.

This creaminess and the clever use of binding agents have made the paste easy to use. Available in a tube, used with both cups and brushes, the paste stays more compact on the tooth surface, thereby avoiding the unpleasant sensation caused by coarse particles left in the patient’s mouth.

Within a few seconds after application (during the cleaning cycle), Cleanic® paste removes extrinsic discoloration caused by chlorhexidine or stains caused by cigarette smoke. (If either of these are present in a patient at a recall of 6 months, the application should be repeated). About 8 seconds after application, the paste automatically starts its polishing action thanks to Perlite technology making the tooth appear smooth and shiny.

After our usual professional oral hygiene procedures (debridement, scaling and root-planing), Cleanic® paste, compared with others on the market, seems to be less apparent in the gingival sulcus.

Pro-Brush™ new generation brushes are very suitable for patients with dental overcrowding or malpositioned teeth. Plastic replaces the traditional metal part and allows the brush to rotate more efficiently. This helps to prevent damage to adjacent teeth.

Pro-Cup™ cups have been designed and developed to avoid pastes being splattered as with traditional cups.

By Dr. Fabio Cosimi D.D.S.
Dr. Susanna Ghezzi D.I.
I-OSTIA Lido, Rome

Cleanic® prophy paste with Perlite technology

A universal prophy paste with Perlite technology

Cleanic®
Prophy Paste for Cleaning and Polishing
Art. No. 3180
3180

Kerr

Before

Procedure

After
Pulp protection in today clinical practice: what about the role of materials?

By Dimitrios Tziadas, DDS, PhD

Vital Pulp Protection and Therapy (VPPT) is the treatment of choice for saving the pulpal tissue in a healthy and functional state, whenever the dental pulp has been compromised by caries, trauma or restorative procedures. Pulp vitality, odontoblast layer, is not essential for mature tooth survival. Mature permanent teeth with an intact pulp can survive for a long time after a successful endodontic treatment. However, the maintenance of pulp vitality in both mature and developing teeth provides benefits, n immature permanent teeth the vital pulp is the last and most integral requirement for continuation of root development and strengthening of the role of the dental crown, with living pulp the capacity of the dentin-pulp complex of mature permanent teeth to resist denin defects and to retain the damaged complex as a functional and vital defensive mechanism of the pulp. The objective of VPPT is to minimize reversible pulpal inflammation and to allow pulp tissue healing and to protect it from exogenous stimuli. It is well recognized that the damaged dentin-pulp complex requires protection from thermal conduction, chemical injury from the overlying restorative materials and further bacterial invasion from dentinal canals or oral bacteria leakage. It must be clarified here that protection from thermal conduction depends mainly on the conductivity of the main restoration and is beyond the scope of the present article. In order to assess the therapeutic validity of the current restorative materials in vital pulp protection, the biology of dentin-pulp complex is briefly reviewed.

Biology of dentin-pulp complex

The pulp and the dentin have been widely considered as a functional unit, because they form an embryological and functional entity. The dental pulp is a connective tissue entirely enclosed by dentin in the pulp chamber of the tooth. Dentin is a collagenous mineralized tissue characterized by the presence of parallel dentinal tubules, forming a semi-permeable substrate which is regulated by the defensive function of the pulp and is effective in protecting the pulp from leaking bacterial threats and chemical irritants. Pulp structure is not only an anatomical structure, pathophysiology, and diagnosis of endodontic diseases are different between primary and permanent teeth. However, recent advances in primary tooth biology demonstrated that primary teeth have a potential for wound healing and tertiary dentin formation. In light of these observations, VPPT in primary dentition has been already re-evaluated and similar techniques as in permanent teeth are widely used (American Academy of Pediatric Dentistry, 2006).

• Similarly, dental treatment

The reader of the present article is encouraged to study a number of excellent papers reviewing experimental and clinical observations as well as the level of evidence in relative clinical research, which have been presented in the symposium held on 2007 in Chicago, Illinois, on “Emerging science in pulp therapeutic issues” jointly sponsored by American Association of Endodontists and American Academy of Pediatric Dentistry, see Pulp Symposium, Journal of Endodontics, July 2008, Volume 34, Number 7S. It has been well recognized that the following critical factors are playing a role:

a. Treatment indications

As has been well demonstrated the VPPT is indicated for teeth with healthy pulp or reversible pulps. More particularly:

1. Pulp protection, where a material is placed on the pulpal surface of a dentinal cavity to act as a barrier between the permanent restoration and the sound dentinal base of the cavity, is indicated for a. Carious or non-curious tooth cavities with remaining dentin thickness less than 2 mm; b. History of lingering or spontaneous pain, negative percussion and palpation tests and positive pulp vitality test, and b. Young permanent teeth after luxation trauma or crown fracture exposing the inner third of the dentin, regardless of the presence of clinical symptoms. Indirect pulp capping is a technique in symptom-free teeth with deep carious lesion where a thin zone of carious dentin is remained to avoid pulp exposure. The ultimate goal of this technique is to complete caries removal just before the pulp exposure, where the potential and irreversible pulp healing can effectively protect the pulp and stimulate tertiary dentin formation. Presence of symptoms of irreversible pulpitis, positive percussion and palpation tests, or radiographic appearance of apical lesion consist absolute contra-indications for indirect pulp capping.

b. Control of infection

It is well-known that the pulp in the wound healing depends largely on the extent to which infection can be avoided (Bergenholtz 2005). Thus, control of pre-operative and post-operative infection, is a critical clinical concern with various VPPT techniques.

• Pathology of dentin-pulp complex: Among various clinical variables that have been accounted as factors playing a role in the outcome of the VPPT, most important are issues related to different patho-physiology and healing potential of the dentin-pulp complex, as in primary, immature and mature permanent teeth:

• Dental treatment of primary teeth must satisfy different goals than treatment for mature permanent teeth, due to the limited life span of primary teeth and their possible relationship to the permanent tooth successor. The anatomical structure, pathophysiology, and diagnosis of endodontic diseases are different between primary and permanent teeth. However, recent advances in primary tooth biology demonstrated that primary teeth have a potential for wound healing and tertiary dentin formation. In light of these observations, VPPT in primary dentition has been already re-evaluated and similar techniques as in permanent teeth are widely used (American Academy of Pediatric Dentistry, 2006).

• Similarly, dental treatment...
of immature permanent teeth must satisfy different goals than treatment for mature permanent teeth, due to the central role of the pulp in the physiologic continuation of root development and in further deposition of primary dentin which strengthen the root dentinal walls. Thus, preservation of pulp vitality is particularly important in the immature permanent teeth, even with very different treatment indications.

e. Remaining dentin

Effective protection from the chemical and bacterial irritants depends on the following two parameters (Smith 2002):

i. The remaining dentin thickness has been widely recognized as the main factor which determines the long-term success of the treatment, in absence of bacteria. In general remaining dentin thickness more than 1 mm is considered to be a safe limit for adequate pulp protection.

ii. Situation and dimensions of the exposed dentinal surface in the cavity seem to influence the overall dentin permeability through the number of exposed and open dentinal tubules.

f. Operative trauma

The operative trauma has been also implicated with pulpal injury and subsequent pulp healing. Frictional heat due to uncontrolled mechanical cavity preparation, over-drying of the exposed dentin, direct damage to odontoblastic processes in deep cavities, and the chemical treatment of the dentinal surface due to acid-etching, may be associated with transient pulp damage and/or increase in dentinal sensitivity, which can delay pulp healing, while also development irreversible pulpitis cannot be excluded.

The role of materials - In general similar materials are widely used in today clinical practice for both sites, pulp protection in deep sound dentinal cavities, and in active carious dentinal lesions, despite the facts that the objectives of the two techniques are clearly different. For many years the hard setting zircon oxide eugenol cements have been used under amalgam restorations, and the non-hydroxide-containing cements have been considered as materials of choice for pulp protection in deep dentinal cavities, especially in cases of indirect pulp treatment. However glass ionomers have been evaluated as superior materials in deep dentinal cavities, while direct application of adhesive materials in the base of the cavities has also been proposed. Recently calcium silicate-based materials, acting as dentin replacement materials, are under preclinical and clinical evaluation.

Four criteria seem to be concerned to the characterization of an effective pulp protective material (see table):

Physical properties

Adherence to dentin, resistance to dissolution, setting time, flow, and dimensional stability represent the most important physical properties of an ideal pulp protective material. The physical limitations of Ca(OH)₂-based materials, such as the non-adherence to dentin, dissolution in tissue fluids and degradation upon tooth tissue rank them in the last position of the materials for using in pulp protection. Lack of any adherence to dentin has also been found for the zircon oxide-eugenol based materials. On the opposite excellent physical and mechanical properties have been reported for the resin based materials. The glass ionomers present several important properties, such as an elasticity similar to dentin, and bonding to dentin and enamel. However glass ionomers are not resistant to water and have a slow setting rate. Improved physical properties have been obtained with the resin modified glass ionomers. Newly released calcium silicate-based dentin substitutes have also showed interesting physico-chemical properties.

Antibacterial activity

It is widely accepted that the ability of the pulp protective material to reduce bacterial leakage and to prevent post-operative growth of leaking bacteria and their invasion into dentinal tubules is the most critical requirement to avoid deleterious pulp inflammation and necrosis (Bergrunholt 2005, Smith, 2002, Tzi-allas 2010). Furthermore several micro-organisms could be isolated from deep carious lesions and hence, the use of a material with antimicrobial activity under-dentinal restorations has been highly recommended. Since bacteria can differentially affect the ability of odontoblasts to repair the dentine barrier function, the rule of capping material in reduction of bacterial growth is important. Histological investigations have demonstrated prevention for bacterial growth in almost 100% of the restorations with glass ionomer-based materials, in caries free teeth of young adults for post-operative period up to one year. In a few recent studies the MTA and hydroxyapatite-based materials showed significantly better antimicrobial activity than Ca(OH)₂.

Biocompatibility

Absence of cytotoxic effects and biocompatibility of the restorative materials are reasonably of critical importance to reduce the possibility of pulp tissue irritation or degeneration. Various cell culture systems, implantation testing models in animals or usage tests in animal or human teeth have been repeatedly evaluated the biocompatibility of materials used as pulp protective bases. Calcium hydroxide-based materials have been much studied and represent the gold standard in the research of dental material biocompatibility. Conventional glass ionomers are highly biocompatible materials, while the resin modified glass ionomers, the resin composites and the adhesive systems have been shown to be considerably more cytotoxic, due to the release of non-polymerized monomers (BISGMA, UDMA, TEGDMA, HEMA). These monomers can cause direct pulp inflammation in toxic concentrations, or dramatic reduction of the defensive ability of the pulp in sub-toxic concentrations. However histologic studies in deep cavities of human teeth are expected to confirm these issues.

Bio specificity

It is associated with the capability of material to stimulate reduction of dentin permeability (barrier function). Systematic investigations on the ability of the use pulp protective materials, including the gold standard group of calcium hydroxide-based materials, to mediate inflammation in the underlying pulp and to...
Editorial report on the Dental Hygiene Day at the 9th CAD/CAM & Digital Dentistry International Conference 09-10 May 2014 Dubai

By Victoria Wilson,
Dental Hygiene Therapist, UK

Dubai, UAE: A truly remarkable day for Hygienists in the MENA, over 100 Hygiene delegates attended the first Dental Hygiene Day on Saturday May 10th, 2014 which was a continuation of the 9th CAD/CAM & Digital Dentistry Int’l Conference, May 09-10, 2014 at the Jumeirah Beach Hotel, Dubai, UAE. Hygienists practicing in the UAE and from other countries in the MENA attended the first of it’s kind in the Middle East.

The timetable included a variety of relevant topics tailored specifically to the Hygiene profession.

The exceptional speakers made it worthwhile for any hygienist to attend.

Prof. Crawford Bain delivered an interesting informative lecture on the maintenance of the dental implant patients, an extremely relevant topic for all Hygienist in light of the growing number of implants being placed and the crucial role of the Hygienist in the necessary maintenance.

Dr. Matthieu Gabriele gave a lecture on Oral Hygiene protocols and complications with various fields of dental treatment, a must know-how for every Hygienist.

Dr. Rasha Ahmed presented the important topic on dentine hypersensitivity management. Hygienists face patients common complaints of hypersensitivity on a daily basis, and the well presented topic by Dr. Rasha was much appreciated by the audience.

Victoria Wilson’s Lecture, the Editor of Hygiene Tribune, focused on communication within Dentistry, a topic essential for the delivery of oral health education and achieving long term compliance and maintenance of oral health.

The afternoon consisted of a hands on course on periodontal instrumentation, with the renowned Prof. Mary Rose Pincelli Boglione from Italy and the International Federation of Dental Hygienists IFDH. Due to the popularity and demand the course was extended to 2 days. We were honored to have such an expert in the profession join us on a revision of the essential skills of scaling and instrumentation. Hygienists are trained extensively on scaling and instrumentation in their education, however it is easy to fall into bad habits. This was an invaluable refresher course for Hygienists and we hope that Mary will join us in the future for more courses.

Dr. Rasha Ahmed also delivered a very informative hands on continuing course in the afternoon on the practical application of the management of dentine hypersensitivity.

In the 7 years I have been living and working in the UAE I have never known for there to be such an extensive program for the profession on one day and for so many Hygienists to be in one room at one time. The year 2014 is an exceptionally exciting time for the profession of Dental Hygiene in the MENA. Four months ago the Dental Tribune Middle East opened the Dental Hygiene Tribune section dedicated entirely to the Dental Hygiene profession. More and more dental and medical professionals are requesting to have a Hygienist on board. Following on from the Dental Hygiene Day we look forward to more Hygienists days by CAD/CAM with more hands on courses, and lectures tailored to the needs of hygienists professionals.

What we all have to keep in our mind is that a healthy periodontium is the backbone to all good restorative dentistry and medical treatment – not in the whole process an essential part in over all health and wellbeing.

Contact Information

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Dental Hygiene Day
15 November 2014
Jumeirah Beach Hotel Dubai
www.appmena.com/aesthetic2014

www.lda.org.lb
BIDM 2014

24th Beirut International Dental Meeting
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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.‡

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† Compared to Philips Dash
‡ Results based on 500-person study. Data on file.

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Unique products for your sensitive patients
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Philips introduces its best brush yet, Sonicare DiamondClean, helping users achieve brushing brilliance every time

Dent al brilliance every time

DiamondClean, helping users achieve brushing

Philips introduces its best brush yet, Sonicare

directs it between and behind

oxygen-rich foamy liquid and

gently whips toothpaste into an

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100% more plaque in hard to

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and which delivers Sonicare's

treatment and switch to Soni-
t activity. Now is the perfect time

to give your teeth the celebrity

treatment and switch to Soni-
care to really experience the difference.

The brush is able to deliver a unique whole mouth clean feeling thanks to its five brush modes that allow you to tailor your brushing according to your needs as well as your den-
t professional's advice. The brush modes range from:

• Clean – the standard mode for a whole mouth clean

• White – removes surface stains to whiten teeth

• Polish – brightens and pol-

ishes teeth to bring out their

• Gum Care – gently stimu-
lates and massages gums

• Sensitive – an extra-gentle

mode for sensitive teeth

Highly charged

DiamondClean's chrome base also features a unique charg-
ging glass that can be used for

mouth rinsing, but also incor-

porates the latest in inductive

charging technology to charge

the toothbrush as it rests in the

glass—making it stylish enough to

display in the most fashion-

forward bathroom.

Not only is Sonicare Diamond-
Clean Philips' most advanced
brush yet, it's also our most easy to use and stylist. Dia-

mondClean's power handle has a ceramic finish and a chrome

accent ring highlights the el-
egant neck of the brush. The

technology in the handle is

hidden so that the sleek matte

white finish of the brush is un-

cluttered by electronic visual

displays. Only when the on but-

ton is pressed are the brushing

modes illuminated to reveal the

array of options. These are

then simply se-

lected by scrolling
down using a one

button action.

When travel-

ling or on the go, Sonicare Dia-

mondClean is de-

signed for conve-

nience with users being able to keep their brush fully charged using a revolu-

tionary USB travel case that
can be plugged into almost any

lap top computer and saves the

 hassle of having to pack plugs

and adaptors. But only the most intrepid travellers need worry

about this advanced feature as Sonicare DiamondClean holds an impressive three weeks charge.

Brilliant cut

Sonicare DiamondClean

brush heads also sport a new diamond-cut tuft formation to

provide you with an even more efficient brushing expe-

rience. The uniquely designed

diamond bristle heads have

44% more bristles than Philips Sonicare's standard sized Pro-

results brush heads, providing you with both superior plaque removal and whiter teeth. The heads come in two sizes – Stan-

dard and Compact – for focussed cleaning in areas of special

need, for orthodontic patients and those with smaller mouths.

Contact Information

For more information about Philips Sonicare DiamondClean or the Philips Sonicare range, including copies of clinical stud-

ies, visit www.me.a.philips.com/e/

oralhealthcare/ar

Hygiene Tribune

by Beverly Watson BDH, Kings College, London

London, UK: It is understood that out

of many professions Dental Hygienists are

in the high risk category of suf-

fering from Repetitive Strain Injury RSI or Carpal Tunnel Syndrome CTS. This article aims to evaluate ways to re-

duce this strain by using the Ultra Sonic Scaler USL as much as possible and by choosing the most beneficial hand instru-

ment on the market today to

reduce this risk.

Two widely used brands of Hand instruments are to be evaluated as a comparison, LM DuraGradeMax and American Eagle XP Technology

Method: Online research publi-

cations.

Conclusion: After reviewing

the information from both LM

and American Eagle instru-

ments, it was found that some

parts of the LM information in

Figure 5 was not able to

clearly state what it was trying to

prove. yet with electron mi-

croscopy photographs and the

Rockwell hardness test proves

the hardness of the cutting edge of American Eagle instru-

ments.

Objectives: To determine the

best ways a Dental Hygienist can

avoid RSI or CTS through-

out their career. This will in-

clude exercises’ and what to

be aware of when choosing ergonomic hand instruments for hand scaling, such as the comparisons LM DuraGrade-

Max and American Eagle XP

Technology. The criteria will be

judged on the handles light-

weight quality, the best grip

and the need for sharpening.

Figure 1. The repeated activity can compress the median nerve travelling through the Carpal Tunnel.

Figure 2. Examples of stretch ing exercises to perform be-

tween patients.

Figure 3. Examples of treat-

ment options for RSI or CTS when the strain has become chronic, and simple exercises are inefficient.

Figure 4: From this

movement and oversree

This clearly describes a

Dental Hygienists average

working day, the repetition of

the same movements. RSI can

affect different parts of the

body the neck, shoulder, elbow,
wrist, hands and wrists. For the

pur-

pose of this article the focus will be on the wrist and hands.

Four common causes of RSI:

1. Repetitive activities

2. Doing a high-intensity activ-

ity for a long time without rest

> Page 20

by Beverley Watson BDH, Kings College, London

Figure 5

Figure 6

Figure 7

5. Poor posture or activities

that require work in an awk-

ward position

4. Holding the instrument USS

or hand scalers with the wrist

is bent. It is best to keep the

wrist in line with the arm not

at an angle compressing the

median nerve (Figure 1).

Signs and symptoms can vary

but the most common are pain,

aching or tenderness, stiffness,

throbbing, tingling or numb-

ness, weakness and cramp.

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

> Page 20

by Beverley Watson BDH, Kings College, London

Figure 5

Figure 6

Figure 7

> Page 20

by Beverley Watson BDH, Kings College, London

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

> Page 20

by Beverley Watson BDH, Kings College, London

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

> Page 20

by Beverley Watson BDH, Kings College, London

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

> Page 20
Are your patients’ dentures truly clean?

Dentures contain surface pores in which microorganisms can colonise.¹

Corega® cleanser is proven to penetrate the biofilm* and kill microorganisms within hard-to-reach surface pores.²

Date of preparation: June 2014.
Ref: CHSAU/CHPLD/0008/14c.

SEM images of denture surface.
*In vitro single species biofilm after 5 minutes soak.

Help your patients eat, speak and smile with confidence with the Corega® denture care regime.

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For full information about the product, please refer to the product pack.
For reporting any Adverse Event/Side Effect related to GSK product please contact us on contactus-me@gsk.com.
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

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 (6.80). After 4 weeks: Control (fluoride-containing toothpaste) group 26.00 (9.14); parodontax® group 19.80 (7.38). *parodontax® vs control p<0.05.
Prevention: Take regular hand breaks to stretch and exercises the muscles, tendons and ligaments. See Figure 2 for some possible exercises.

Breaks don’t only include time away from scaling, but also time away from the computer and writing notes. Typing can also compress the nerves in the Carpal Tunnel.

Treatment: If it is not possible to take long term time out from the activity causing the repetitive strain on the small muscle groups, then it is necessary to take regular short breaks and stretch (Figure 2, 3).

A hand splint, the hand is held in a relaxed position to take pressure of the Median nerve running through the Carpal Tunnel and as a final resort surgery.

A brief history of Hygiene

The earliest recorded text associating through the Carpal Tunnel and as a final resort surgery.

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PRECISION CLEAN BRUSH HEAD PROVIDES

UP TO 5x

GREATER REDUCTION

IN PLAQUE BIOFILM ALONG THE GUMLINE

5x

Oral-B®

Oral-B, most Dentist Recommended Toothbrush Brand worldwide

* vs. a regular manual toothbrush

continuing the care that starts in your chair
KaVo CAD/CAM workflow with the new products ARCTICA AutoScan, KaVo multiCAD Virtual Articulator and VITA ENAMIC

By KaVo

With the production of two monolithic posterior crowns, the KaVo CAD/CAM application technology demonstrates a practical case in which the new CAD/CAM products ARCTICA AutoScan, KaVo multiCAD Virtual Articulator and VITA ENAMIC for KaVo ARCTICA play a major role.

Described below are the following individual steps, which consist of:
1. Order preparation
2. Scanning
3. CAD construction
4. Preparation for manufacture
5. Manufacturing
6. Completion

Order preparation: 50 seconds

First, the practitioner, the patient and the respective technician are defined in the order entry form. The second step consists of the definition of the indication including all parameters. In the present case, this concerns the creation of two crowns to be made of VITA ENAMIC Regio 46 and 47. The parameters for the respective practitioner can be referenced in the KaVo multiCAD software. This function guarantees consistent quality regardless of the originator of the order (Figure 1, 2).

Scanning: 180 seconds

This case is scanned with the new fully-automatic ARCTICA AutoScan. The scan process is very simple as the software guides the user step by step through the scan process. The individual scans are performed completely automatically. First, the upper jaw is scanned, followed by the lower jaw. If necessary, single stumps may then be scanned separately. This is followed by a vestibular scan allowing the correct positioning of the jaws by the software (Figure 4). The next step consists of matching the individual jaw scans and the vestibular scan by marking three identical points on the respective jaw and vestibular scan. Afterwards, the software calculates the exact position of the upper and lower jaw scans (Figures 4, 5, 6).

Construction of the restoration in the KaVo multiCAD software: 180 seconds

In the KaVo multiCAD software, the contact relief of the corresponding jaw is displayed in the scan software. For analytical purposes, it may be displayed in color. The respective color and intensity indicate the distance to the antagonist.

Afterwards, the articulator KaVo PROTAR evo 5B is started in the KaVo multiCAD software. The respective patient-specific settings of the physical PROTAR articulator such as, for example, the condyle track inclination and the Bennett angle, are entered into an entry mask. The correct positioning of the models in the virtual articulator (KaVo PROTAR 5B) is done automatically. Based on the scan of the articulated models in the ARCTICA AutoScan and the positioning of the models by the KaVo Splitcast system, the correct positioning is automatically transferred to the CAD-software. This positioning also applies to models that were inserted into the articulator by means of a facebow.

After the adjustment of the patient-specific parameters, the motion tracks are simulated and any interferences are corrected by the software (Figures 7, 8, 9).

The illustration shows a laterotrusion to the left (Figure 10).

In the subsequent construction process, the movements of the jaws may be visualized at any time (Figure 11).

The manufacture of the two VITA ENAMIC crowns on 46 and 47 is performed quickly and easily by means of library teeth that are automatically positioned onto the preparations and may be loaded into the situation via a simple mouse click. Furthermore, the library teeth may subsequently be matched to the individual occlusal relief of the chewing surface. The user is able to adjust the suggestions of the software via a wizard (step-by-step assistant) at any time during the construction process. Various tools
Giomers are a remarkable class of bioesthetic restorative materials that exhibit the aesthetics, strength and durability of nano-hybrid resin composites, further enhanced with the benefit of fluoride and anti-plaque effect pertaining to S-PRG fillers.

These unique fillers are manufactured through Shofu’s patented PRG filler technology that imparts Beautifil II, Beautifil Flow, Beautifil Injectable and FL-Bond II with protective fluoride benefits and greater tissue tolerance.
Now is the time to consider investing in your own CBCT System

By Ernesto Jaconelli

This Century has seen the introduction of 3D imaging as a readily available dental diagnostic tool. This trend has been inspired by the development of both Cone Beam Computed Technology (CBCT) and PC storage capability making 3D imaging more convenient, easier to use, and affordable.

To be able to view the area of interest in all three dimensions significantly improves the accuracy of diagnosis and this in turn makes for better patient treatment. Each year new systems are becoming available such as the new CS 8100 3D System from Carestream Dental. These new systems are now significantly smaller, more versatile and user friendly than their predecessors. The CS 8100 3D has a “resting” width of 33cm (110cm when in use) and weighs only 92Kgm so will fit easily into most compact dental clinics.

A very important feature of all modern CBCT systems is that they provide the Dentist with a choice of volumes that will be right for the area of interest. These volumes are known as the Field of View (FOV). The CS 8100 3D for example gives choices from taking a 2D Panoramic to capturing a selection of 3D FOVs of 4 x 4 / 5 x 5 / 8 x 8 and 8 x 9 mm. As with all x-rays it is essential to minimise the dose to the patient – the larger the FOV the more dose to the patient. Each area of dental surgery will require a different FOV depending on the treatment being considered so it is essential to have a choice of FOVs to select from.

For a single implant a FOV of 5 x 5 mm will be sufficient and the dose to the patient in this case will be similar to that from a 2D panoramic scan. However for the preparation of multiple implants or surgical guides then a single arch FOV of 8 x 8 / 8 x 9mm FOV would be selected. Dentists who specialising in Implants were the first to fully appreciate the benefits of 3D imaging such that it is now unusual to find one who does not have their own CBCT system.

For Endodontists, the key diagnostic tool is always their surgical loupes. But they are also adopting 3D image to reveal more clearly any additional canals that are present and possibly missed from a 2D image as well as their exact position and apical areas. A sectorial FOV of 5 x 5 mm will provide a very high definition image for an Endodontist to be able to examine the area in precise detail.

Until now Orthodontists have mainly been satisfied with a 2D panoramic view. However having a CBCT system that switches easily from a 2D panoramic to 3D image allows the Orthodontist to select a 3D view when required. Retention and angulation for example are more precisely diagnosed from an 8 x 5 / 8 x 9 mm FOV.

3D imaging will soon be the norm for dental diagnostics requiring all dentists to be familiar with the technology and capable of analysing 3D images. There has never been a more appropriate time to consider having your own CBCT System. Manufacturers are supplying more in depth training such as at the Carestream Dental Training Centre at Ajman University of Science and Technology, and now that CBCT systems are available from 40,000€, a return on the investment can be achieved within two years.
Simple, planned aesthetic orthodontics for the General Practitioner

By Dr. Tif Qureshi

Dr. Tif Qureshi shows how digital technology has moved progressive smile design on and the enormous benefits this will have on planning and consent.

Digital Smile Design is making a come back in a very smart and intelligent form through the use of live video, cameras, and keynote presentations.

I commend the users of this technique as it is clearly a far better form of smile design planning than just using plain static before and after pictures with someone else’s smile stitched into place.

However in cases where there are alignment issues, I would still argue that any patient who does not at least go down the pathway of alignment and bleaching, cannot really see their teeth change in a dynamic way.

I have found that patient’s feelings about their smiles change, often they think they want one thing but after they see their smile change a little they start to appreciate it in a different way. How can someone really be consented unless they are given the opportunity to bleach their teeth, perhaps with slight alignment and bleaching.

This case is the perfect example and will show how progressive smile design also using digital technology can produce beautiful predictable results that often require far less invasive treatment.

We use digital technology in a different way of course and this is all to do with planning and consent. Previously with Inman Aligners, we had to use Lesling models. These are effectively fairly crude stone models which take a cut and once repositioned in wax the aligner is then built on that model. As soon as the aligner is fitted into an uncorrected mouth the forces are there to push the teeth to the final position. The real downside of it is the wax creates quite large inaccuracies. Also it is very difficult to see how much adjustments have been made to the teeth to get them to fit within the curve. This is even more so of a problem for flared teeth which have been out of the arch for many more years. These teeth tend to be highly triangular and often need more targeted adjustment to get them to fit within the arch form. You can visualize the roots of these teeth, it is almost impossible to accurately know how much production is required to each.

Of course with digital 3-D printing this has all changed. The difference if you like it is night and day. We can also use print models to show the patients the proposed outcome. This is excellent for the consenting process. Untreated patients will now see any compromises areas and the final outcome. If they are not happy they could reject the treatment before it starts.

A case
A 22 year old gentleman did not like the appearance of his teeth especially because the two centrals was so prominent. He had considered having porcelain veneers done just to improve his smile in one treatment. He did not like the appearance of his enamel and also the discrepancy in the shape of his front teeth. We showed him the occlusal view of his teeth and he could see that the upper anterior is one mildly misaligned. Indirect veneers would have been fairly aggressive towards the preparation of the upper central incisors. By showing examples of other cases where simple alignment had dramatically improved the aesthetic value the patient agreed to try to align his teeth first before having veneers done.

Consent part one
A full orthodontic examination was carried out. All orthodontic options were discussed and the patient understood the benefits of fully comprehensive orthodontics, and was also given a range of short-term techniques that he could have chosen. He declined comprehensive orthodontics on the basis that he only wanted to deal with his anterior teeth.

He chose to have an Inman Aligner because of the shorter wear time and the minimal cost impact on his overall treatment desires. Our first goal was to evaluate the aesthetics and function to decide on landmark and reference teeth. As part of the digital planning process; these teeth are not moved and ensure the setup accommodates these teeth to ensure the proposed curve is not flared out or over contorted.

In this case the patient also had a retained upper left deciduous tooth (no canine had developed). Fortunately this tooth was in the right position so it became the reference tooth and hence no orthodontic force would need to be applied to it. Both upper centrals needed to be retracted by about 5mm and the laterals advanced by about 1.75mm exactly. These setups can be viewed as digital files in 3D if needed beforehand by the dentist and adjustments can be made if needed. Once we are happy, the 3D model was printed.

Consent part two
The 3D model was returned and we could view the proposed setup made according to the space-wise instructions

Figure 5: Overjet before
Figure 4: Overjet reduced and proposed on 3D print
Figure 5: 3D Print Occlusal

An appointment was made with the patient to sit down and examine the models. At this point the patient clearly sees any compromises in the posterior region of his mouth. These were again highlighted but the patient insisted he did not want these treated. The over jet was also discussed with the patient he could see a reduction but not complete closure, he was happy with this.

You can see the width differences in the anterior teeth that would require adjustment and
tooth shaping with PPR (predictive proximal reduction). This made it far easier for him to understand the processes required to create the space. Finally he could also see the differential wear in his tooth outline that would be evident after alignment. He clearly understood that edge bonding and tooth contouring might be required after alignment and bleaching were complete. That is assuming he did not want to continue with porcelain veneers.

It was noted that the patient had reviewed and understood the 3-D model and what it was proposing. The Inman Aligner was then built and fitted.

Treatment

Inter-proximal and Predictive proximal reduction were carried out in a progressive and measured manner over 5 visits. This was done to ensure good anatomy and to reduce the risk of gouging, over stripping and poor contacts. With Inman Aligner treatment stripping is never carried out in one go.

Composite anchors were also placed in a timed and sequenced manner to ensure the forces could be directed at the right time. This allows for rapidly increased treatment times.

After only nine weeks the patient’s anterior teeth had nearly aligned. Bleaching trays impressions were taken at this stage. Super sealed trains are used and poor contacts. With Inman Aligner treatment stripping is never carried out in one go. Composite bonding was carried out on the 7, 9 and 10. A composite veneer was placed on the 11. All these were carried out with only roughening and no prep or bevel. Venus Diamond composite from Heraeus Kulzer was used. I find that the Opaque shade allows superb blocking out of light meaning that if layered as dentine, it means a long bevel is not required to block out the join. Enamel shade can then be placed thicker towards the incisal edge.

A wire retainer was fitted and the guidance adjusted to ensure there were still balanced excursive contacts on the left side so the load was not focused on the deciduous tooth.

Roughening, total etch Opti-bond solo and Venus flow were used to bond the wire in place.

A clear essix retainer was also given to the patient to wear at night initially then to use occasionally and to have as a back up if the wire de-bonded.

Discussion

On viewing the sequenced shots it is clear to see the changes.

The patient was delighted that he had emerged from the treatment with his own teeth looking more attractive rather than having ceramic porcelain veneers. As good as ceramic restorations are, they will always require further treatment/maintenance and replacement.

On a 22 year old if alignment, bleaching and bonding can satisfy the patient that it has to be better than placing ceramic veneers. The problem with digital smile design is that the patient is not really given the opportunity to see the teeth change slowly and in situ.

It is fine if whitening, bonding and alignment are part of those protocols but arguably patients should not be shown images of multiple veneers until they can visualize their own teeth looking better.

You can see how very subtle changes can dramatically improve the appearance. Even though the colour is not truly homogenous and the teeth have a mottled appearance the most important thing here is that the patient was completely delighted with the treatment.

Ultimately a patient being happy with their own smile has to far outweigh the parameters that are set up traditional smile design.

Final images at the 6 month review are also shown.

Contact Information

Dr Tif Qureshi teaches Inman Aligner Training
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or email: inman@mdentlab.com
www.inmanalignertraining.com
may be used for this purpose, for example free forming, virtual wax knife, scaling, turning and shifting of teeth.

Interferences remaining after the construction will be displayed by the software and automatically removed in consideration of both static as well as dynamic factors (by means of the virtual KaVo PROTAR Evo 3D) including the previously identified motion tracks. This allows for a drastic reduction or even the complete omission of subsequent follow-up work in the mouth of the patient for the practitioner. Not only does this facilitate time and cost savings, the danger of chipping may be reduced as well (Figure 12, 15).

The following colour illustration shows the occlusal pattern after dynamic adjustment (Figure 14).

In the image, one can clearly recognize the deviations (color markings) between the static and dynamic structure and the adjustment of interferences in the chewing relief.

The dynamic adjustment may be displayed over the static one as wire netting. Any interferences to be expected are clearly recognizable (Figure 15).

After the dynamic adjustment, the finalized VITA ENAMIC crowns may be displayed in the KaVo multICAD module TruSmile in a photo-realistic manner (Figure 16, 17).

Preparation for manufacture in the KaVo CSS: 60 seconds

The next steps for the completion of the dentures are performed in the KaVo CSS software, which is a job, material, tool and machinery management software by KaVo.

First, the manufacturing method is defined. This means that the user has the opportunity to send the produced,
open STL data of the restoration to his ARCTICA engine, his Everest engine or to other KaVo milling partners via the free KaVo Everest portal. The work to be manufactured and the predefined material to be used may be reviewed in a 3D view. If necessary, additional modifications such as, for example, a change of the material may be made.

After the selection of the KaVo ARCTICA engine as the production machine and a VITA ENAMIC for KaVo ARCTICA block, which was previously booked into the KaVo CSS via RFID technology, the nesting, i.e. the positioning of the restoration in the virtual material block, may be performed (Figure 18).

Figure 18

Now, the blanks are inserted in the block bracket of the ARCTICA engine and affixed with a torque wrench with a defined tightening torque (Figure 19, 20, 21).

Aferwards, the tool stack with the tools required for the Vita ENAMIC – in this case, 4 different grinding tools with diameters between 0.6 – 3.6 mm – is inserted.

These tools were also previously booked in the KaVo CSS software via RFID chip and assigned to the glass ceramic tool stack. The advantage is that the tool service times are precisely logged and that the ARCTICA engine uses a traffic light pattern (green, yellow, red) to show the user when a tool should be exchanged. This also helps to minimize application errors.

In case of an automatic tool change in the KaVo ARCTICA engine, the tools are once again inspected with a laser for breakage or faulty positioning once they have been removed from the stack.

The processing is started at the touch of a button on the touch-screen of the ARCTICA engine or, alternatively, directly at the PC (Figure 22).

Completion of the VITA ENAMIC crowns: 180 seconds each

After the successful production of the two restorations on the KaVo ARCTICA engine, the VITA ENAMIC crowns may be separated from the material block. The ARCTICA engine may be connected to a KaVo lab handpiece (ERGOgrip and POWERgrip) and used to further process the works. Prior to the start of the grinding procedure, there is also an opportunity to reduce the diameter of the connectors to a minimum at the end of the production process, so that the time expended for the separation of the restoration becomes negligible.

In the grinding procedure, the VITA ENAMIC crowns are polished in a time-saving manner with the tools from the VITA ENAMIC polishing set. An additional subsequent individualization of the work is possible with the colours of the VITA ENAMIC stains kits. In this case, an additional individualization was omitted upon the request of the patient (Figure 25, 26).

Thanks to the use of the virtual articulator during the construction in the KaVo multiCAD software and the precise 5-axle technology of the ARCTICA engine, the work could be inserted directly into the mouth of the patient and corrections of the occlusal relief could be waived. As can be seen, precisely integrated process chains pay off.
Fig. 7: ... was adhesively cemented and seated.

stability and accurate reproduction of details. The material already exhibits a surprisingly good surface quality after nulling; this simplifies the further manual processing as well as saving time. Polishing, staining and glazing are particularly quick and simple with the corresponding polishing sets. No firing cycles, e.g. a glazing firing, are required. We’ve received only positive feedback from the patients; this case is no exception. Along with natural esthetics, the surface of the restorative material feels smooth to the tongue, which contributes to a high degree of wearing comfort.

On account of the special material concept and its resulting physical properties, such as an elasticity modulus of 50 GPa and a Weibull modulus of 20, etc., VITA ENAMIC is much less vulnerable to the shear and compressive forces acting on the stomatognathic system than many traditional CAD/CAM ceramics. As a result, it offers a particular potential for certain risk groups, such as patients with parafunctions (teeth grinding and clenching), regardless of the manufacturer’s official recommendation for use only in the case of patients with normal occlusion.

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Table: A schematic overview of the pulp protective materials’ performance in clinical and experimental investigations.

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<td>Capping material for partial pulp exposure</td>
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References

The personalization offered by Ormco Custom can reduce treatment time on average by 37% with 7 fewer office visits per case. With the unrivaled efficiency that Ormco Custom provides, you’ll have a little more of that priceless “you time” to hit the back nine. It’s your world – Ormco Custom is just here to help you maximize it.

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