**Excellence Awards in Digital Dentistry 2015**

By Dental Tribune MEA/CAPPmea

On the eve of the 10th CAD/CAM & Digital Dentistry International Conference, CAPPmea celebrated its 10 year anniversary by awarding 28 dental professionals for their contributions to Digital Dentistry since the 1st event in 2005 as part of the Excellence Awards 2015. The celebrations took place under the majestic skyline of Burj Al Arab on the ‘Arena’ grounds of Jumeirah Beach Hotel in Dubai. Thank you to all dentists, dental technicians and sponsors who supported us.

During the casual gala dinner party, Dr. Dobrina Mollova together with her business partner Mr. Tzvetan Deyanov showed their appreciation on behalf of CAPPmea for the support and contribution of the nominees during the last 10 years since the foundation of the company.

The Excellence Awards in Digital Dentistry 2015 were handed out to all participants and included various prizes from the dental industry gifted by Sirona, Nikon, Philips Sonicare, Southern Implants, Dubai Medical Equipment and Oral-B.

Furthermore on behalf of CAPPmea, Dr. Dobrina Mollova awarded the pioneering companies who supported the CAD/CAM & Digital Dentistry International Conference since its first 2005 edition, Sirona, 3M ESPE, Zirkonzahn, Qualident and KaVo.

A full list of the winners of the Excellence Awards in Digital Dentistry 2015 can be found on www.cappmea.com/awards2015

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The Winners

“The Best Educated in Digital Dentistry”
2015 Excellence Awards

Dr. Munir Silwadi | Dr. Munir Silwadi Dental Center
Dr. Andreas Stanke | Da Vinci Dental Clinic, Abu Dhabi
Dr. Fadi Edward Daou | Daou Dental Clinic, Abu Dhabi
Dr. Ghassan Mohamed Merhi | Merhi Dental And Orthodontic Center, Abu Dhabi
Dr. Hisham Hassan Alameddien | Al Noor Hospital, Abu Dhabi
Dr. K. M. Abdulrahman | Al Gharbia Hospital, Abu Dhabi
Dr. Mohammed Iskandarani | Healthpoint Hospital, Abu Dhabi
Dr. Omar Aloum | Al Hikma Medical Center, Abu Dhabi
Dr. Reema Sharawi | Munir Silwadi Dental Center, Abu Dhabi
Dr. Riad Mansour Emghaoech | Royal Specialised Medical Centre, Abu Dhabi
Dr. Ziad Baraee Kassem | Victory Dental Clinic, Abu Dhabi
Dr. Bahab Suroor | Al Suroor Dental Clinic, Al Ain
Mr. Anshul Cornuco | Tawam Dental Centre, Al Ain
Ms. Julia Gaudia Despabiladeras | Tawam Dental Centre, Al Ain
Dr. Amin Karji | Netcare Clinic Center, Dubai
Dr. Dominique Caron | Versailles Dental Clinic, Dubai
Dr. Naja Yusef Hassan | Al Badras Health Clinic, Dubai
Dr. Thomas Varghese | Bethel Specialty Hospital, Dubai
Dr. Iyad Eserdiq | GMC Clinics, Dubai
Mr. Bachwan Koutoh | Dubai Health Authority, Dubai
Dr. Bruno Czylweck | Drs. Nicolas & Asp Dental Clinic, Dubai
Mr. Nestor O. Datu | American Dental Center, Dubai
Dr. Hazza A. Alhobeira | The University Hail, Hail
Mr. Amjad Hassan Harrou | Amjad Dental Factory, Riyadh
Dr. Mohd Wessam Kabbani | Kabbani Specialist Medical Center, Jeddah
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By 3M ESPE

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The restorative is available in both Aplicap™ and handmix delivery, as well as in six shades for simple color matching. The new nozzle design of the Aplicap delivers a consistent and easy application. The handmix delivers its easy handling, and it can now be used for restricted stress-bearing Class I and II restorations, thanks to its compressive strength and surface hardness. It can also be placed in bulk, eliminating the need for layering, and giving dentists an economical option for a general bulk restorative material.

With its time-saving capabilities as well as with leading technologies and solutions in the dental market in the region, we carry out a variety of dental programs for the dentists of different specializations. We have dedicated ourselves to the region in many ways where dentists can take part in smaller hands-on sessions or bigger educational events. Every year we conduct over 500 educational activities in MEA region. On annual basis we participate in the regional dental events such as AEDCG, SDS Conference, SADA Congress, CAD/ CAM & Digital Dentistry International Conference, etc. presenting new 3M ESPE products both at our booth and within the scientific program.

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Now, get them out of the chair faster!

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- **Stress-bearing properties** enable extended indications
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Ketac Universal restorative … because the most caries-prone patients are also the most restless.

For more information please visit: [www.3MGulf.com/espe](http://www.3MGulf.com/espe)
Restoration of endodontic teeth: An engineering perspective

Introduction

Identifying the canals and ensuring them to be able to instrument and obturate the tooth is necessary to clinical success. But restoration of the endodontically treated tooth is critical to long-term success. It does not matter if we can com- plete the endodontic portion of treatment if the tooth cannot be restored. So, we need to look at the restora- tion phase from an engineering perspective as to whether the restoration needed to reinforce the remaining tooth so that it can manage the repetitive loading that necessitates a ferrule design? This article will discuss the importance of ferrule in ad- hosing a tooth to the fixture to use posts and what materials are best.

Ferrule: How important is it today?

Ferrule has long been an im- portant concept in dentistry but has been de-emphasized with the bonding evolution. Yet this concept is as important today as it was prior to dental bonding. But what is a ferrule? A ferrule is a band that encircles the exter- nal aspect of the tooth. It is generally used to strengthen the tooth, thus securing the margin of the crown to the root (Fig. 1). This repetitive loading and strain at the cervical portion of the tooth during mastication, margins with inad- equate ferrule may demonstrate root post and core separation (Fig. 7). This may result from breakdown of the ce- ramic tip, leading to vertical root fracture. Freeman, et al, in their published study, stated, “Fatigue loading of three different post and core de- signs with the presence of a full cast crown leads to preliminary failure of leakage at the restoration and tooth that is clini- cally undetectable.”

The literature supports that coronal leakage may be a ma- jor factor in failure of endodon- tic treatment. As previously discussed, when loaded during mastication, margins with inade- quate ferrule may demonstrate root post and core separation (Fig. 2). This repetitive loading and strain at the cervical portion of the tooth during mastication, margins with inad- equate ferrule may demonstrate root post and core separation (Fig. 7). This may result from breakdown of the ceramic tip, leading to vertical root fracture. Freeman, et al, in their published study, stated, “Fatigue loading of three different post and core de- signs with the presence of a full cast crown leads to preliminary failure of leakage at the restoration and tooth that is clini- cally undetectable.”

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The absence of a cervical ferrule has been shown to be a contributing negative factor, giving rise to considerably higher stress levels reaching the root. When no ferrule was present, the prefabricated metal post/composite combination generated greater cervical stress than cast post cores. Yet, the ferrule seemed to cancel out the effects of root reconstruction material on the intensity of the stresses. With a ferrule, the modulus of the post should be slightly greater than or equal to that of the dentin order to redistribute the stresses into the root and to prevent the occurrence of fracture under interocclusal load. When failure does occur due to overloading, failure typically is in the coronal portion, frequently demonstrating fracture of the core at the post interface instead of root fractures. Post failures occurring under the cusp are of clinical importance as the tooth is overloaded, and the core is not retained, whereas the mesial/distal and lingual roots may be spared.

The material the post is fabricated from should have an elastic modulus that more closely approaches that of dentin. The material must be resistant to the forces without distortion. The material properties of fiber posts were higher than the metal post and similar to dentin.22


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By Nancy M. Costa-Lawson, USA

The evolution of the dental hygienist’s role in the assessment of a client’s oral health from a singular approach to a collaborative multidisciplinary approach is evident in the treatment of clients with sleep disorders. Knowledge of the variations in sleep disorders, medications, treatment needed, as well as the various applications will be vital to the dental health-care providers. Pagel (2012) says that by 2015, 40 percent of the U.S. population will have some form of sleep disorder; 18 million Americans have sleep apnea, which affects all ages, both sexes and may be genetic. The most prevalent form occurs in 4 percent of middle-aged men and 2 percent of middle-aged women.1

As with all medical conditions, early detection and baseline data will aid in monitoring changes in the patient’s health and providing useful information in treatment planning and intervention. Sleep apnea in the past has been viewed as most typically related to snoring; however, there are different types of sleep apnea disorder. The most prevalent and known is obstructive sleep apnea syndrome. Another type, central sleep apnea, is less common. A third type, complex sleep apnea, combines both the obstructive and central types.

What is obstructive sleep apnea syndrome? Obstructive sleep apnea syndrome (OSAS) is a common, but underdiagnosed disorder that is potentially fatal.2 According to de Almeida et al. (2006), “It happens more frequently during REM sleep, and breathing stops for 10 to 60 seconds, which results in reduced levels of oxygen dissolved in the blood.”3

The patient with the OSAS does not know this is happening. A person’s perception of sleep is often inadequate. These individuals may have a mental and physical state – and lead to additional problems in the oral cavity.

What is complex sleep apnea? Complex sleep apnea is a combination of obstructive sleep apnea and central sleep apnea. Some patients with obstructive sleep apnea develop central sleep apnea while on treatment with continuous positive airway pressure (CPAP).4 This article focuses on obstructive sleep apnea and how it relates to the oral cavity.

Causes of obstructive sleep apnea syndrome: Tongue muscles, soft palate and uvula relax and/or sag (Fig. 2), causing snoring, difficulty breathing and breathing cessation. Obstructive sleep apnea and sleep medications can exacerbate the condition. Snoring and gasping for air causes the person to wake several times a night, preventing the person from getting the proper sleep needed to function. Sleep apnea is often present in people who are overweight, who have physical abnormalities such as a deviated septum or have other abnormalities of the nose or throat. The snorer tries to breathe, creating a tighter seal, which decreases oxygen flow to the brain. The sleeper awakens gasping for air.

Factors and effects: Studies on sleep apnea are fairly new, and diagnostic evidence is evolving. Snoring is one of the symptoms of obstructive sleep apnea syndrome. However, not all individuals who snore necessarily have OSAS. Friedlander (2000) says, “Obstructive sleep apnea is partially open, obstruction occurs frequently and results in a loud irregular snoring sound caused by air rushing through the narrow passage and stimulating the soft palate, uvula, throat walls and tongue to vibrate.”4 If an OSAS patient is left untreated, this condition can worsen over time. Risk can increase for hypertension, stroke, myocardial infarction, anoxic seizures and sudden death while asleep.5 Sleep apnea can be alleviated with oral devices and/or surgical procedures, however some complications have arisen in the oral cavity because of some of the devices used to correct or minimize obstructive sleep apnea.

Signs and symptoms: Dental professionals may be the first health-care providers to suspect possible OSAS in a patient because of signs and symptoms exhibited within the oral cavity. These include: macroglossia (Fig. 3) and enlarged pharynx, narrowed posterior airway space resulting from a long soft palate by the uvula lying below the base of the tongue; the tongue lying above the mandibular plane of occlusion and small mandible.6 Signs and symptoms of OSAS while sleeping may include drooling, xerostomia, restless-ness, bruxism, choking or gasping, snoring, breathing pauses and diaphoresis. But an individual’s symptoms associated with OSAS are not limited to sleeping problems. During waking hours the patient may experience depression, difficulty concentrat-ing, fatigue and insomnia. Other signs can include gastroesopha-geal reflux disease (GERD), irritability and sleepiness throughout the day. Coughlin says, “If OSAS continues to be untreated or it is never diagnosed, the sleeping disorder may elevate blood pressure and lead to potential for mortality increases.”6

What to look for: Magliocca says, “The population with OSAS is a heterogeneous group, and have a wide range of physical attributes. Not all patients with OSAS have all of these physical features.”7 The most common orofacial characteristics encountered include a retrognathic mandible, narrow palate, large neck circumference, long soft palate (which leads to dentists being unable to visualize the entire length of the uvula when the patient’s mouth is open wide), tonsillar hypertrophy, deviated nasal septum and relative macroglossia.

Potential outcomes of non-treatment: Patients with OSAS have interrupted sleep patterns because the obstruction of airflow causes prolonged interruptions in their breathing while they sleep (up to 40 seconds). Because the condition can lead to a reduction of oxygen in the blood stream, a host of medical complications can occur. Individuals with obstructive sleep apnea can experience worsening snoring, which is caused by vibration of the partially collapsed soft palate as air passes. Respiratory events, which deplete certain stages of non-REM and REM sleep, contribute to sleep fragmentation and unrefreshing sleep.8 Because of the lack of sleep, an OSAS sufferer may have difficulty concentrating and staying awake during the day. When sufferers sleep on their back, gravity pulls the jaw and tongue down and back. This causes the mouth to open and the tongue to drop back into the airway, nar-rowing the air passage.

Treatment: Oral devices and surgical intervention are the procedures used to treat OSAS. An oral appliance (Fig. 4) is a small acrylic device that fits over the upper and lower teeth or tongue (similar to an orthodontic retainer or mouth guard). This device slightly advances the lower jaw or tongue, which moves the base of the tongue forward and opens the airway. This improves breathing and reduces snoring and apnea. The appliance is fabricated and customized for each patient by a dentist experienced in the treatment of snoring and sleep apnea. The appliances are comfortable and well tolerated by patients. Appliances are easy to place and remove, easy to clean and are convenient for travel.

Non-surgical treatments are available, including positional therapy. The two main categories of oral appliances currently in use are the mandibular advancement devices (MAD) and the tongue retaining devices (TBD). The mandibular advancement devices, made of acrylic materials, are custom fabricated for each patient. The impression for the acrylic devices can be made in the dental office for lab fabrication. The devices fit comfortably over the upper and lower teeth, positioning the lower jaw slightly forward, advancing the tongue and soft tissues of the throat to open the airway. Some of the ‘repositioners are designed to hold the mandible

The role of the dental team in the management of the patient with sleep apnea

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Matching Gutta-percha cones with TF/TF Adaptive Instruments

By Prof. Gianluca Gambardini, Italy

Introduction
With the widespread use of the rotary NiTi instruments, matched-taper gutta-percha (GP) cones (of greater tapers) were developed to make root canal obturation techniques easier, more predictable and improve quality. Nowadays many manufacturers commercialise matched-taper GP cones made to be used with a specific instrumentation technique. As a consequence, not only the single cone regained popularity due to the fact that single matched cone could now produce a satisfactory three-dimensional fill; also warm vertical techniques gained advantages from the use of a matched master cone, by reducing the risk of voids or gaps inside the filled endodontic space.

However, the greater amount of variability in design and dimensions of commercially available NiTi instruments and GP cones of greater tapers can easily create confusion among practitioners, especially if they use instruments and cones of different brands. If selected gutta-percha cones do not precisely match with the used NiTi instruments, the whole concept falls apart and consequently not only they may not solve the problem, while choosing a smaller tipped cone may significantly increase the risk of iatrogenic errors like underfilling and/or overextension of the cone through the apical foramen, because the tug-back in the coronal part does not allow correct apical cone fitting.

Therefore the best and easiest solution is to choose TF/TFA gutta-percha cones that precisely fit the root canal preparation achieved by the TF/TFA instruments and allow ideal three-dimensional filling and good apical tug-back. In the alternative, a KSF user could use both types of cones (the .04-.06 cones and TF/TFA) because they will both nicely fit the root canal preparation in the apical and middle thirds.

Additional clinical tips for TF/TFA users
So far, dimensions and sizes have been discussed to help clinicians to understand problems in matching instruments and cones.

However, there are also clinical ways to try to solve problems that can be encountered during these procedures. These are tips that can be useful not only with TF/TFA but with many instrumentation techniques.

Create more coronal flaring. TF/TFA are very efficient instruments and very good at lateral cutting. They are ideal instruments for all techniques that require brushing and/or circumferential filing.

Therefore, if a GP cones does not perfectly match the root ca

matching for potential conditions associated with medications being used to treat sleep disorders.

Appendix

Patients answering yes to any of the following questions may need to be referred to a sleep physician:

• Do you snore?
• Have you ever been diagnosed with high blood pressure?
• Has there been any witnessed stopping of breathing or gasping for breath during sleep?
• Do you know your neck size? If so, is it more than 17 inches for men or 15 inches for women?
• Have you ever been told to use a CPAP or breathing machine while sleeping?
• Do you and your partner sleep in separate rooms because of your loud snoring?
• Do you doze off unintentionally during the day?
• Do you often wake up feeling tired or having a headache?
• Do you have problems concentrating for long periods of time?

References

Editorial note:
The full list of references is available from the publisher.

About the Author

Nancy Costa-Larson, RDH, BS, MHA, has worked in the dental field for 20-plus years as well as in the medical community for three years.

She works as an active clinician and assistant clinical director in a non-profit clinic in Birmingham, Ala., working with students from the University of Alabama Dental School providing dental treatments to the uninsured community in the area.

Costa-Larson was a delegate in the Massachusetts Hygiene Association Board. She received an associate in science in hygiene at the Springfield Community College, followed by a bachelor of business at University of Phoenix, from which she earned a master’s in healthcare administration from Argosy University in Florida.

Contact her at whitesmiles4youth@gmail.com (Nancy Costa, Sleep Apnea Forum).
nal preparation by not reaching the working length, one possible solution is to increase coronal flaring by brushing with the last instrument. By doing so a TF/TFA instrument will increase the dimensions of the prepared canal in the coronal part, solving the problem related of “GP Taper-lock”.

Correct apical fitting. Clinicians may experience two different clinical problems in the apical fitting: the need for a better apical tug-back, which may require slightly cutting the tip of the master cone, and the fitting related to the amount of canal transportation.

The first case may happen due to the different dimensions; tolerance of a GP cone may be slightly smaller than the nominal size, increasing the risk of overfilling during obturation. In such cases, the advice is to slightly increase the dimensions of the master cone by cutting 0.5/1 mm off the tip, or ideally to precisely recalibrate the master cone using a tip-snip device. This can also happen if a canal is iatrogenically slightly over-instrumented (due to a mistake in the working length determination or in the position of the rubber stop on the file); the apical constriction is now modified and the cone fitting must try to accommodate this mistake by increasing the tip size of GP master cone.

TF/TFA are significantly more flexible than the majority of competitor NiTi rotary instruments. As a consequence they tend to follow more precisely and maintain the original trajectory of root canals, minimizing canal transportation. Canal transportation is a mistake that frequently occurs when a rigid file is inserted into a curvature, and tends to straighten it by cutting more in the inner part of the curvature coronally and in the outer part apically. However, this mistake, which can affect quality of debridement, makes insertion of master GP cone easier, especially when complex, double or triple curvatures are present.

This is why the TF/TFA user may clinically experiment with a slightly more difficult insertion of the master GP cone to the working length. If this problem occurs, once again slightly increasing circumferential filing can help.

Conclusions

Hence we may conclude that TF/TFA users should preferably use TF/TFA cones that perfectly match the prepared canals. By doing so, fitting the master GP cone becomes much easier and more predictable, and in the very few cases where some problems can still be found, the provided clinical tips may help clinicians in understanding problems and finding proper solutions.

References

Teeth and gum sensitivity effects over 50% of adults

By Jordan

Sensitivity is a growing oral care health concern and preventing sensitivity starts by keeping the teeth enamel strong & healthy. Sensitivity is in a lot of markets the Nr. 1 concern influencing purchase. Consumers want products that work well but are also gentle to their teeth enamel and gums.

Many people suffer from sensitive teeth and it can start at any time. It is more common in people aged between 20 and 40, although it can affect people in their early teens and when they are over 70. Women are more likely to be affected than men. If sensitivity effects so many people why are they not buying more “sensitive” oral care products?

Research tells us that most consumers, as many as 90%, find it difficult to choose products in-store. So how can we help consumers find the right products for them? It can start at the dentist. Dental professionals recommend that consumers choose toothbrushes with soft bristles as these are gentle on their teeth enamel and gums. They also prefer smaller heads as it is easier to navigate around the mouth and clean difficult areas, especially the back molars where cavities tend to start. Manufacturers can also help by making “sensitive” products more attractive and readily available with clear and easy to understand information. In 2014 there was a rise in the number of launches with enamel focus.

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The BIG Issue: Let’s Talk Bad Breath

Beverly Hills Formula Managing Director Chris Dodd explains how to discuss bad breath with patients!

By Beverly Hills

Bad breath (halitosis) is a common problem that affects most adults at some point during their lives, and for up to a quarter of adults, on a more regular basis (1). In fact, it is estimated to be the third most frequent reason for seeking dental aid following tooth decay and periodontal disease (2). Despite this, halitosis continues to be a taboo subject. A survey once revealed that only one in 10 people are willing to tell friends and family that they have bad breath (3). No matter how close we are to someone we just can’t find it in ourselves to tell that person they have bad breath for fear of hurting their feelings. But for those who suffer from bad breath, it can have a significant impact on their personal and social life and can even be a sign of underlying health problems.

As a dental professional your advice and recommendation carries considerable weight and by educating patients on how to deal with bad breath you can help eliminate bad odour from their lives and save them from further embarrassment.

Approaching the subject of bad breath

As a dental professional, you are trained to deliver a positive oral health message to your patient in a professional and tactful manner.

Often the patient may not even be aware they have bad breath so its important to be considerate of their feelings and talk to them in a conversational and informal manner. Set the tone by asking a few common questions about their oral health. If it’s apparent the patient is embarrassed and does not wish to discuss the subject further, talk to them in general about halitosis and good oral care or wait until another time; they may even approach you at their next appointment. However, it is important to inform patients that bad breath can be a sign of underlying health problems and should not be ignored.

In many cases, the patient will be relieved that you instigated the conversation and “revealed all” to you. In these situations you should explore the subject some more as described below.

Explaining the causes and symptoms of bad breath

Many people are confused about the causes of their bad breath so it’s essential to make them aware of all the common factors and put them at ease. Generally a result of a build-up of bacteria in the mouth brought on by left-over food, the causes and symptoms will differ for every patient so it’s ideal to start by informing them that bad breath is relatively common and not usually a health concern.

• Ask about their oral hygiene routine - inadequate brushing or flossing causes food particles to become stuck between the teeth and decay inside the mouth
• What type of foods and drinks do they consume? Garlic, onions, coffee, cigarettes and alcohol are just some foods and drinks that affect the breath.
• Do they suffer from dry mouth (xerostomia) and find it difficult swallowing or speaking?
• Have they suffered from any respiratory or bacterial activity recently i.e. nasal discharge, cataract, coughing, sore throat or sinusitis?
• Do they smoke?

Helping patients combat bad breath

Openly discussing bad breath with patients will enable you to identify how much of a concern it is for them and recommend a solution to help eliminate the bad odour. Put their mind at rest by confirming that bad breath can be easily addressed by following some simple oral care procedures:

• Brush teeth and gums for two minutes, twice a day. Recommend a toothpaste specifically developed to combat bad breath; leaving a fresh “minty” flavour after brushing and containing anti-bacterial agents and anti-bad breath ingredients; activated charcoal (as in Beverly Hills Formula Total Breath Whitening toothpaste) is a great agent helping to eliminate bacteria causing bad breath and neutralise remaining odours, leaving your patients’ breath feeling fresh all day long.
• Floss between teeth using dental floss or interdental brushes.
• Mouthwash (such as Beverly Hills Formula Total Breath Whitening mouthwash) will rinse away the bacteria that cause bad breath and offer anti-plaque properties.
• Tongue cleaners to brush the back of the tongue will remove food or odour causing bacteria.
• Chew gum to stimulate saliva and stop the mouth drying out.
• Consume foods and drinks that assist in preventing bad breath; baked soda, peppermint oil, fennel seeds, mastic gum, non-concentrated cranberry juice, natural yoghurt, and fruit. A handful of parsley will prevent bad breath from the stomach. Advise they keep a diary of foods and drinks; you may be able to identify a common factor.
• Quitting smoking is one of the best recommendations you could give, not just for eliminating bad breath but for reducing the risk of mouth cancer.
• Drink plenty of water and green tea but avoid coffee. Fizzy drinks provide short term relief but the bad breath problems in the long-term.

Promoting Bad Breath Awareness

By helping your patients combat bad breath you will be making a dramatic improvement to their personal, professional and social life, boosting their confidence to eat, speak and laugh with friends and family again.

Nominate a “fresh breath” expert in the practice or hold a “fresh breath” day/week/month; you’ll be surprised at how many obstacles will come forward to end their fight against bad breath. Leave flyers/brochures on halitosis around the practice, in reception or in the waiting room, and patients will feel more inclined to tackle the subject.

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By Dental Tribune MEA/CAPPmea

**“Ivoclar Vivadent is one of the leading dental enterprises in the world”**

*By Dental Tribune MEA/CAPPmea Ivoclar Vivadent is known for its continuous passion, vision and innovation. How do you portray the mission/visions to your big group of clients in Middle East?*

Dr. Ibrahim Soubt: Passion – Our customers and employees are at the centre of our attention. They are the basis for all that has been accomplished by our company.

**Vision – We anticipate tomorrow’s needs and tomorrow’s market.** This is the strength on which we base our product development and planning and by which we define the direction in which our company will go.

**Innovation – Our goal is to continuously challenge every product and process to find better, more effective and efficient solutions.** We search for innovations that create opportunities for our customers.

**With the acquisition of Wieland, Ivoclar Vivadent offers a full solution towards dentists and dental technicians.** What has this meant for your regional activities and how is the feedback?

Ivoclar Vivadent is one of the leading dental enterprises in the world with a comprehensive range of products and systems for dentists and dental technicians. All-ceramics is one of the core competences of the company. With the takeover of Wieland Dental, Ivoclar Vivadent strengthens its position in the field of all-ceramic product systems, as well as it will widen the array of unique CAD/CAM materials and equipments. We at Ivoclar Vivadent are very pleased to have Wieland Dental join the Ivoclar Vivadent Group.

If you look at the products offered by Ivoclar Vivadent, you can realize the uniqueness of its position, Ivoclar Vivadent understands the business process and offers products, technologies and innovations involved on each of the dentists and dental technicians levels, in other words from the impression of the prepared teeth, until the seating of the restoration in the patient mouth, whether this restoration is made of Composite, Metal Ceramic, All ceramic processed conventionally or by CAD/CAM, all is done with high quality and highly coordinated products.

**How would you best describe the level of Dentistry in the Middle East region?**

It differs from country to country and even from city to city within a country, but I can say confidently that it is improved and still improving noticeably through the last decade, of course implementing the CE credit points as pre-requisite to get or maintain the license which led to the formation of different dental groups and large centers in the area, these educational events and educational centers are contributing largely to the improvement of the skills of dental technicians and dentists through wide variety of courses and seminars. Of course UAE and Dubai in particular are leading in this domain. In general I would say the level of dentistry in the area is good. In some countries the level is average or even below average in others is good and very good, so I just took the average of it all which is good.

**Ivoclar Vivadent is well known for continuously educating its customers and potential clients. What are the most important education activities you organize and events you attend in the MEA region?**

In order to answer this question properly we have first to describe the areas of strength of Ivoclar Vivadent:

- **Direct Restoratives**: which represent a traditional core strength of Ivoclar Vivadent, and a number of our restorative materials have been ranking amongst the leading products in the dental market for years, an example of those are: Tetric N Ceram, Tetric N Ceram Bulk Fill, IPS Empress Direct and Tetric N Bond universal, bluephase N and many others.

- **Fixed Prosthetics**: Inlays, onlays, veneers, crowns and bridges made of All-Ceramics ensure highly esthetic restorations becoming an integral part of dentistry, and Ivoclar Vivadent is the market leader with its IPS e.max and IPS Empress. Ivoclar Vivadent also offers metal supported crowned and bridges, cutting edge ceramic furnaces, and a coordinated range of finishing materials. And last but not least the CAD/CAM Technology equipment and materials.

- **Removable Prosthetics**: Ivoclar Vivadent takes the exact standards required by dental professionals in removable dentures, prosthetics, age and type specific tooth molds are part of the range as well as the highly accurate devices and apparatus for fabrication of high precision dentures.

Coming back to your question regarding the dental education, which represent our 4th strength area, Ivoclar Vivadent is involved with high standards of training and further education, providing future oriented, practically relevant knowledge. Our International Center of Dental Education (ICDE) in Schaan is one of the most advanced education centers, comprising a variety of lecture rooms, laboratories, practice rooms and 2000 square meters lecture theater. Regional training centers across the globe contribute to the remit of the ICDE and assure a high level of knowledge about our high quality products, our training and educational courses are widely attended by dentists, dental technicians, opinion leaders, hygienists, dental assistants, dental students and dealers. In this process Ivoclar Vivadent has built one of the largest networks for dental education. We always implement this knowledge of training in all our events in the area, and our courses are promptly booked 10-15 days after announcing them and this alone indicates the high quality of the educational events we provide.

**Do you read the latest Dental Tribune news from across the world? What do you expect from Dental Tribune MEA as your regional media partner?**

Yes, I do usually once it is published, I read through it in the evening using the Dental Tribune App for iPad. I expect from Dental Tribune MEA to continue the good job and to provide improvements continuously to the content. I would like to see a special section addressed to people in the dental industry whether they are manufacturers or distributors, I imagine that this section should contain: business analysis, M&A, Trends, etc...
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Functional & Cosmetic Excellence: Revitalization of a Proven Treatment Philosophy

By Straty Righellis, DDS, Oakland, CA & L. Douglas Knight, DDS, Louisville, KY

Functional and Cosmetic Excellence (FACE Tx™) is an approach to orthodontics treatment that establishes measurable treatment goals for six elements that form the basis of comprehensive, interdisciplinary, high-quality orthodontic care:

• Functional occlusion
• TMJ health
• Facial balance
• Optimal dento-gingival esthetics (smile design)
• Periodontal health
• Stability

For each of these goals, the originators of the FACE Tx™ discipline have defined specific elements that create a framework for the systematic evaluation of the esthetic and functional needs of each patient and a method to assess treatment results. These treatment goals are supported by reputable studies published in well-respected, peer-reviewed journals. Sharing these goals and the means to achieve them with an interdisciplinary team—the orthodontist, the dentist and/or other specialist(s)—provides you, the orthodontist, an opportunity to work with esteemed colleagues to create outstanding results for beauty, health and function.

Building successful practices is an important side benefit of this approach. Developing the skills required to manage and function within FACE Tx interdisciplinary treatment teams increases the complexity of cases one can treat. The collaborative interaction with experts in their respective fields (prosthodontists, periodontists, cosmetic and general dentists and surgeons), who ascribe to the same principles of tooth positioning and jaw function, creates a knowledge base to treat to predictable, on-time, optimal results while meeting and/or exceeding patients’ expectations. As a result, one’s referral network expands with resultant practice growth.

Worldwide Program of Instruction FACE Tx offers one of the world’s only postgraduate interdisciplinary continuing educational programs. Offered in numerous countries to university-trained orthodontists, it provides didactic instruction and hands-on experience. Through a series of 5 to 7 one-week sessions, a team of established educators and practitioners convey this unique curriculum. The associated FACE Tx fraternity incorporates a lifetime learning forum for thousands of doctors who have adapted FACE Tx principles to their practices.

The FACE Tx teaching staff builds on each participating clinician’s knowledge base. The full-time faculty—Drs. Jorge Ayala (Santiago, Chile), Renato Cocconi (Parma, Italy), L. Douglas Knight (Kentucky, USA), Domingo Martin (San Sebastian, Spain), Jeffrey McClendon (New York, USA), Straty Righellis (California, USA), and Carl Roy (Virginia, USA)—all manage active private practices and have extensive educational and clinical experience. The teaching faculty combines considerable years of skills and knowledge to formulate the FACE Tx approach to diagnosis, treatment planning and execution.

Figure 1a-d. The elements of a mutually protected occlusion: (a) optimal overjet and overbite in centric occlusion; (b) right working excursion; (c) right balancing excursion; (d) right protrusive excursion.
While functional occlusion serves as the foundation for the FACE Tx approach, the discipline further differentiates itself by integrating facial balance with dento-gingival esthetics for a comprehensive approach to diagnosis, treatment planning and execution. Dr. Renato Cocconi and surgeon, Dr. Michael Rafai, have analyzed the standards for optimal facial balance and dento-gingival esthetics and have quantified the relationship of the inclination of the upper incisors with the alar base and the pedestal of the nose. These elements are important diagnostic findings for the development of specific treatment goals and metrics to assess the esthetic quality of treatment results. Dr. Jorge Ayala has quantified the correlation of the upper incisors with the alar base and the pedestal of the nose. These elements are important diagnostic findings for the development of specific treatment goals and metrics to assess the esthetic quality of treatment results.

What the FACE Tx Course Teaches
During the comprehensive one- to two-year FACE Tx program instruction, participants develop a solid foundation of knowledge and skills in the following areas that is clinically practical:

1. In-depth evaluation of joint function and occlusion
2. Mounting models with the most up-to-date instrumentation in simulating patients’ jaw movements
3. Latest analytical techniques to assess facial balance and esthetic smile design
4. Multidisciplinary case diagnosis and computer assisted treatment planning (VTO)
5. Efficient and simple treatment mechanics with self-ligating appliances
6. Establishing one’s own interdisciplinary treatment team
7. Treatment and practice management strategies and marketing techniques to enhance one’s interdisciplinary network
8. Knowledge of the type patients one can treat successfully and language to use that will offer patients choices

The FACE Tx teaching faculty shares proven techniques about how to adapt course instruction to clinical practice. There are several keys to successful treatment outcomes:

1) See everything before you begin treating the patient. This tenant mandates a complete and thorough diagnostic evaluation (seeing everything) from temporomandibular joint analysis to occlusal analysis to the elements that comprise a pleasing smile design;
2) Document specific treatment goals with specific assessment measurements, or the visualization of treatment outcomes for tooth and jaw joint positions and key aspects of facial balance and pleasing smile design;
3) Utilize skillfully engineered and exactly manufactured orthodontic appliances and develop efficient mechanical systems—from bracket placement to debonding—that require minimal patient cooperation, foster good hygiene and result in less chairtime (Figure 2);
4) Undertake a never-ending quest for continued improvement in practice efficiency. Finishing on time with predictable outcomes allows one to provide optimal results and meet or exceed patients’ expectations.

Conclusion
The FACE Tx philosophy incorporates comprehensive diagnosis and treatment planning, efficient treatment mechanics and the latest orthodontic advancements for treating each patient’s dental, facial and gnathological systems. Its aim is a collaboration between the goals of orthodontics and comprehensive dentistry that incorporates interdisciplinary coordination.

This approach expands the network of professionals who share principles of tooth positioning and jaw function. Such collaboration greatly strengthens one’s referral base as these colleagues understand the value of the orthodontic specialty and the specific value of FACE Tx. It promotes the viability of the orthodontic specialty through the development and maintenance of viable practices that combine function with beauty. The ultimate aim of FACE Tx is to foster excellence in orthodontic patient care and treatment through education, research and collaboration.

Dr. Righellis graduated from UCLA Dental School and received his orthodontic specialty certification from the University of California, San Francisco. He maintains a private practice and serves as an associate clinical professor at the University of the Pacific and University of California, San Francisco. Dr. Righellis is a diplomate of the American Board of Orthodontics, is on the editorial review board for the American Journal of Orthodontics and lectures domestically and internationally on ex- cellence in clinical orthodontics.

Dr. Knight received his dental degree from the University of Kentucky and was awarded a certificate in orthodontics and dento-facial orthopedics from New York University. Dr. Knight completed a comprehensive two-year clinical program in occlusion and orthodontics at the Roth-Williams Center for Functional Occlusion. In private practice, Dr. Knight is a diplomate of the American Board of Orthodontics. Dr. Knight is on the editorial review board for the American Journal of Orthodontics and lectures domestically and internationally on new orthodontic techniques and interdisciplinary dentistry.

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By KaVo

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Paediatric Dentistry: A Case of the Unerupted Maxillary Permanent Central Incisor and its Multi-Faceted Management

By Dr. Ghada Hussain, UAE & Dr. Iyad Hussein, UAE

Introduction
Monitoring the developing dentition is part and parcel of a general practitioner’s (GDP) routine and this relies on the basic knowledge of tooth exfoliation and eruption times. Delayed eruption of maxillary central incisors can be a reason that parents/carers bring their child in for a dental assessment. Nevertheless, detecting this anomaly by a GDP by chance on routine examination can occur. According to Yacob et al (2010) intervention for the delayed eruption of maxillary incisors, beyond the normal eruption dates, is needed in many cases. For example, if the eruption of the anterior incisor tooth occurred greater than six months previously; or if both central incisors remained unerupted and the lower incisors have erupted greater than one year previously or there is deviation from the normal sequence of eruption (e.g. lateral incisors erupting prior to the central incisor). This issue is important from the interceptive orthodontic point of view and it may have an effect on the facial aesthetics and psychology of the child, in addition to some difficulties in pronouncing some letters for example “S” which will lessen the patient’s self-esteem and social interactions. We report a case of an unerupted permanent maxillary central incisor and its multifaceted treatment in a child patient.

Causes of the unerupted maxillary permanent central incisor
• Heredity (cleft lip and palate, cleidocranial dysostosis, supernumerary teeth, hypodontia, ectopic tooth germs, gingival fibromatosis, tissue scar, odontome, generalised delayed eruption).
• Environmental (trauma, recession, periodontitis, caries, swelling, paraplegia, endocrine abnormalities).

The incidence of unerupted maxillary central incisor in 5-12 year old children is 0.13% and the prevalence is 2.6%.

Investigations
When an unerupted maxillary incisor is suspected, a full set of investigations should be carried out including a medical and dental history, family history, history of dental trauma. A clinical investigation and examination should include direct palpation to locate its correct position by parallax (i.e. buccal or palatal). Management depends on the findings
• The presence of an unerupted maxillary central incisor in 5-12 year old children is 0.13% and the prevalence is 2.6%.

Diagnostic Summary
• 8 ½ year old anxious girl
• Delayed eruption of 21 & an inverted conical supernumerary mesiodens palatal to 21

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Dental caries of the primary molars 55, 65, 74, 75, 85, 84
• Unsealed first permanent molars
• 11 in cross bite
• Gag reflex

Treatment Plan

In lieu of the problem list, the following treatment plan was carried out:

Phase 1
• Dental prevention (Fissure sealants of the first permanent molars, Fluoride, diet analysis/advice and oral hygiene advice)
• Monitor the eruption of 21 for another 5 months.

Phase 2
• If no further eruption occurred and at the advice of the consultant orthodontist: arrange for the surgical removal of the supernumerary tooth with or without a gold chain attachment on 21 to allow extrusion of the said tooth.

• As the patient was dentally anxious (could not cope with having treatment under local anaesthesia or without inhalation sedation) and also needed restorative treatment it was decided to surgically remove the impacted supernumerary under general anaesthesia (GA) and restore the teeth at the same time (Complete Oral rehabilitation under GA).

• LT’s mother consented for the aforementioned treatment to be carried out under GA. This was carried out in a GA day case setting.

The elective day case GA

The following treatment was carried out under the elective GA:

a) Restorative treatment
- Fissure sealants of the 6s
- Pulpotomies with stainless steel crowns on 85, 84, 74, 75 and composites with fissure sealants on 55 & 65

b) Surgical treatment
- After giving local anaesthesia, a continuous palatal intracrevicular (sulcular) incision was carried out from 54 to 64 (Fig. 5)
- Raised a mucoperiosteal flap with the nasopalatine bundle exposed and preserved (Fig. 6)
- The palatal bone was exposed and a bulbosity was noted in the supernumerary (8) area. The overlying "egg shell" bone was removed with an osteotome. The $ was identified carefully as not to be confused with tooth 21 (Fig. 7)
- The $ tooth was elevated atraumatically as possible (Fig. 8 a, b & c)
- The bone was filed and irrigated with saline and tooth 21 was incisally-exposed. A decision not the place a gold chain attachment on 21 was made as 21 was not covered with bone (Fig. 9)
- The flap was repositioned and interrupted sutures were placed (resorbable sutures) after exposure of 21 with a small buccal apically repositioned flap (Fig. 10 a & b).
- Extraction of loose 52, 62
- A post surgical intra-operative assessment was carried out (Fig. 11 a, b & c)

Follow up post surgery

At one-week follow up, the patient was reviewed. She had no complaints. Tooth 21 had begun to erupt (Fig. 12). At one-month’s follow up, tooth 21 had erupted in cross bite. Tooth 11 was already in cross bite.

Phase 5
• This phase included interceptive orthodontics which involved the cross bite correction of both teeth 11 & 21.

Upper and lower aligment impressions were taken (with difficulty due to LT’s gag reflex) to fabricate an upper removable anterior segment palatal expansion.

Fig. 1. Palatal intracrevicular incision
Fig. 6. Raising a palatal mucoperiosteal flap
Fig. 7. Exposure of the supernumerary tooth 8 bulge palatally.

Fig. 8. (a, b & c) show sequence of careful elevation of the supernumerary (8) tooth.

Fig. 9. A survey of the surgical site after irrigation and bone filling was made.

Fig. 10 (a & b). Repositioned palatal flap and wound closure with resorbable sutures. Tooth 21 is now exposed after a small apically repositioned flap made.

Figs. 11 (a, b & c). Show the immediate post operative views

Fig. 12. Cross bite correction of both teeth 11 & 21.

Fig. 13. Flowering limeaid

Fig. 14. Wax
Fig. 15. PMMA
Fig. 16. Titanium

Fig. 17. Wood
Fig. 18. Splint material
Fig. 19. PMMA for hard seat

Fig. 20. Co/Cr
Fig. 21. Zirconium
Fig. 22. AG* system

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we will wait for the eruption of 22.

normal phenomena at this stage and will subsequently close. The patient may corrected 4 months following surgery. There is a midline diastema, which is a

Fig. 16 (a & b). Final result. The anterior crossbite of teeth 11 and 21 had been

sion appliance (with an anterior expanding screw) and posterior bite blocks to correct the ante-

Fig. 13. Upper removable orthodontic appliance with an anterior expanding palatal screw; to correct the cross bite of 11 & 21. The expansion key is to the right.

terior cross bite (Fig. 15).

The appliance was activated us-

ing the key (seen in Fig. 15) and the patient was asked to wear the appliance for 24 hours a day (except at meal times) (Fig.14).

When she was reviewed a month later, tooth 11 was corrected and the bite but tooth 21 was still in cross bite. LT subsequen-
tly lost the appliance, so an alter-

native method to correct the cross bite without subjecting the patient to new impressions (due to her gag reflex) was used. We placed glass ionomer cement (GIC) on the occlusal surface of the upper incisors, (except at meal times) (Fig.14).

This would allow for spontane-

ous correction of the anterior cross bite of 21 due to the pos-

itive pressure of the patient's tongue. At two-month follow up, tooth 21 had moved but was still in cross bite. We placed a com-

posite ramp/ restoration on 21 incisally, to finalise the corre-

ction of the cross bite. One month later, tooth 21 was over the bite and in the correct anterior-posterior position (Fig. 16 a & b).

Discussion

Supernumerary teeth occur in 1.5-3.5% of cases in the perma-

nent dentition. Supernumerary-
ties may present as tuberculate, conical, supplemental, inverted, pegged shaped or odontome shaped teeth. There is a male to female ratio approximately 2:1.4 They are more frequent in max-

illa to mandible ratio around 5:1 and are called mesiodens in the maxillary anterior region. The effect of supernumeraries

causing the failure or delayed eruption of permanent incisors was reported to be in 28% to 38% of the cases. Tuberculate supernumerary teeth are more likely to cause obstruction.6 In 54-78% of the cases removal of the supernumerary will result in the permanent incisor erupting spontaneoussly within an average of 16 months7. In this case, the inverted conical super-

numerary was obstructing the eruption of 21, and its removal facilitated the eruption of 21 al-

most immediately. Correction of anterior crossbites is of the greatest importance because they (if left untreated) may cause attrition to the labial surface of the upper incisors, fractures or mobility of incisor teeth or gingival recession. The treatment modalities adopted here fit with the best current practice UK guidelines.1,3

Conclusion

Monitoring the developing den-

tion may reveal anomalies that require multifaceted interven-

tion by the paediatric dentist. The paediatric dentist skills should cover the range of restor-

ative, interceptive orthodontic and oral surgical procedures as demonstrated in this case. GPs must always check for delayed eruption of permanent incisors especially if one had erupted more than 6 months prior. If detected, an appropri-

ate referral should be made in a paediatric dentist for overall management. We recommend following the Royal College of Surgeons of England (RCSEng) Guidelines (2001) on manage-

ment of unerupted maxillary incisors.

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Immediate implant placement and loading in the anterior maxilla

Is insertion torque and implant stability quotient (ISQ) an influence of a big value?
A two clinical cases report.

By Rabih Abi Nader, Lebanon, Carine Tabarami, Lebanon

Abstract
Immediate implant loading is considered nowadays a successful viable treatment, even though many criteria’s needs to be considered in order to insure implant procedures success, especially in the anterior maxilla.

The aim of this article is to assess the influence of the stability quotient and insertion torque on the immediately placed and loaded implants in anterior maxilla by exposing two clinical cases and reviewing it through a literature review.

Keywords
Immediate implant, stability quotient, insertion torque, anterior maxilla.

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Nowadays the use of immediate implant loading protocol is considered an attractive option in order to preclude dramatic post extraction bone resorption.

Buccal alveolar plate loss following tooth extraction in the maxillary anterior may lead to palatal implant positioning with esthetic complications.

Immediate loading of implant-supported restorations replacing missing tooth could be a successful procedure. Many clinical reports suggest that implants for the mandible have higher survival rates than those for the maxilla.

Immediate placement and loading of single implants placed in fresh extraction sites carried no risk of failure in the present cases.

The purpose of this article is to compare the parameters associated with the implant insertion torque for enhancing primary stability at implant insertion during immediate implant placement and to identify the relation between these parameters.

Literature review
The successful outcome of any implant procedure requires a series of the patient-related and procedure-dependent parameters.

- Insertion torque
A torque corresponds to the association of the cutting part of the tip of implant in the bone and to the friction between implant surface and the hole in the bone. It depends also on how sharp is the cutting tip of the implant, in the surface texture and design of the implant and on the blood supply. The diameter also plays an important role, since a narrow implant will have a lower torque.

A study conducted by Turkyilmaz et al. showed a strong correlation between the primary stability and insertion torque values of Branemark system at the time of implant placement. An insertion torque should be around 30-40 N/cm in order to have good implant stability. An insertion torque less than 30 N/cm seems to significantly impair the immediate implant loading by interfering with the primary stability.

- Implant stability quotient (ISQ)
Implant stability can be measured by non-invasive clinical test methods (insertion torque, periotest, resonance frequency analysis (RFA)). RFA with Osstell instrument, has been introduced by Meredith and used in clinical studies. The resonance frequency analysis (RFA) calculates the stiffness of the bone and implant interfaces from a resonance frequency as a reaction to oscillation placed on the implant-bone system. A correlation between implant stability quotient (ISQ) and implant micromobility was established. A correlation of the implant oscillation under a given transducer load is mainly dependent on the character of the implants bone fixation with the implant stability quotient (ISQ) as a unit of measurement and ranges with the increasing stiffness of the interface from 0 to 100 units.

- Maxillary v/s Mandible anatomy
Anatomical site plays an important role in the success of the immediate implant placement and loading. The bone in the maxilla is considered anatomically different than mandibular area. Therefore more risk of implants failure. It has been proven using CT tool that local bone density has a prevailing influence on primary implant stability which is important for implant success.

It is well proven that the bone around the implant has better quantity and quality in the mandible than the maxilla.

- Surgical procedure influence
Bone drilling is associated with the rise of temperature in the drilled site. Immediate implant placement will lower the extent of the treatment time and will prevent the rise of temperature.
Clinical cases

Case 1

A 54 years old man presented to our clinic with tenderness in the upper right lateral incisor area as a chief complain. Patient presented no significant health problems. The Extraoral examination showed a traumatic occlusion focused on the tooth (Figure 1). The intraoral examination showed tenderness on percussion and a mobility type II. Periapical radiograph showed a horizontal fracture of the root with limited radiolucency in the periapical area (Figure 2). A 4x11.5mm (Any Ridge Implant-Megagen) was placed (Figure 3) after conservative atraumatic removal of the lateral incisor tooth with a 30 N/cm insertion torque. Xenograft was placed buccally after the buccal hiatus proved to be more than 2mm (Figure 5), with implant stability quotient (ISQ) measured to be 75 (Figure 4). Having a high RFA (Resonance frequency analysis) an immediate provisional tooth was placed under occlusion (Figure 6, 7). Four months post operatively, the provisional crown was replaced by a permanent cemented restoration (Figure 8). A two years follow up showed good results with no bone loss.

Case 2

A 38 years old woman consulted our clinic for evaluation of the upper left lateral incisor. The patient did not have any medical conditions and was not taking any medications that were associated with compromised healing response. An intraoral examination showed a traumatic occlusion focused on the tooth (Figure 1). The intraoral examination showed tenderness on percussion and a mobility type II. Periapical radiograph showed a horizontal fracture of the root with limited radiolucency in the periapical area (Figure 2). A 4x11.5mm (Any Ridge Implant-Megagen) was placed (Figure 3) after conservative atraumatic removal of the lateral incisor tooth with a 30 N/cm insertion torque. Xenograft was placed buccally after the buccal hiatus proved to be more than 2mm (Figure 5), with implant stability quotient (ISQ) measured to be 75 (Figure 4). Having a high RFA (Resonance frequency analysis) an immediate provisional tooth was placed under occlusion (Figure 6, 7). Four months post operatively, the provisional crown was replaced by a permanent cemented restoration (Figure 8). A two years follow up showed good results with no bone loss.
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Given the two clinical cases, and considering the clinical evidence-based parameters, immediate provisional crowns should be proposed with immediate implant placement if an appropriate initial insertion torque of 30 N/cm and stability quotient (ISQ) not less than 65. Immediate loading of implant-supported restorations replacing single missing teeth is considered a successful procedure. A significant correlation was found between bone density and implant stability parameters that indicates that clinicians may predict the primary stability before the final prosthesis is placed and they modify their treatment dependent on each relevant parameter.

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Management of gingival recession defects - a case report

By Dr. Olivier Carcuac, Sweden

Introduction
Gingival recession, referring to the exposure of the root of a tooth caused by loss of gingival tissue and/or apical displacement of the gingival margin from the cemento-enamel junction (Wennerberg 1996), is a common clinical observation. According to Kassab et al. (2005), more than 50% of the population exhibits gingival recessions. Gingival recession has a multifactorial etiology associated with anatomical factors or pathological factors (Figure 1). Plaque-related inflammation and traumatic brushing have been considered primary or triggering factors in gingival recession. Furthermore, predisposing factors have also been identified: bone fenestration and dehiscence, position of the tooth within the dental arch, thickness of the marginal gingiva, high attachment of the labial frenulum to the gingival margin (Wennström 1996), and avoiding causative factors, positioning is a contributing factor, appropriate consideration to orthodontic correction should be considered. If the recession is successfully stabilized by identifying the initial treatment phase and will in most cases prevent further progression of the recession. Vigorous brushing should be addressed by advising patients to carry out an appropriate brushing technique (i.e. modified Bass technique) with a soft/medium toothbrush, a less abrasive dentifrice. When tooth mis-positioning is a contributing factor, appropriate consideration to orthodontic correction should be considered. If the recession is related to a piercing, its removal should be recommended. If the recessions have been successfully stabilized by identifying and avoiding causative factors, and by eliminating hypersensitivity, no further treatment might be needed. However, in cases of objectionable aesthetic alterations, progressive recessions, or increased hypersensitivity, surgical correction using mucogingival plastic surgical techniques such as gingival grafting should be considered.

The objectives of gingival grafting are (i) to provide a degree of root coverage and (ii) to enhance the amount of keratinized attached gingival tissue around the tooth. While the latter of these two objectives is very predictable, the amount of root surface coverage may vary depending on the severity of the recession defect. Periodontal plastic surgery is a case report

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been described in the literature to treat the gingival recessions.

- Pedicle soft tissue graft procedures

A pedicle graft involves repositioning donor tissue from an area adjacent to the recession defect to cover the exposed root surface (coronally advanced flap, laterally sliding flap, flap-papillary flap, tunneling technique). These techniques have many advantages as no second surgical site is needed and as the flap retains its own vascularization from the base of the flap. To minimize tissue trauma and thus improve the aesthetic result, these surgical techniques have over the years been modified and improved (Raetzke 1985, Allen 1994, Brunski 1994, Zucchelli and De Sanctis 2000).

- Free-slip soft tissue graft procedures

A free soft tissue graft is indicated when there is no acceptable donor site present in the area adjacent to the gingival recession defect or when a tacker marginal tissue is desirable. This surgical approach requires

- Donor Site Preparation

The second step was to harvest a subepithelial connective tissue graft from the palatal mucosa. The selected area extended from the distal aspect of the right first premolar to the mesial aspect of the right first molar. The single-incision technique was used to remove the graft. The graft was removed with a thickness of 1.5 mm (Figure 6g) and the palatal site was stitched with single sutures.

- Graft Positioning and Suturing

The graft was positioned under the flap and over the exposed root surface of tooth #13 and secured with 6/0 Prolene® sutures. The buccal flap was coronally advanced and sutured with 6/0 Prolene® sutures (Figure 6b). Straumann Emdogain® was applied over the gingival margin for 5 minutes to enhance soft tissue healing (Figure 6e).

- Postoperative Instructions

The patient was instructed to take analgesic medication (paracetamol, 750 mg) three times a day for 4 days and an antibiotic (amoxicillin, 1.2 g) twice a day for 15 days. All sutures were removed after 14 days (Figure 6f). The patient was followed up weekly during the first month, monthly up to the third month, and annually up to the second year.

- Clinical Evaluation

The healing process was uneventful, and the patient did not report pain or discomfort during the overall postoperative period. The color of the tissues was homogeneous 2 weeks following the surgical procedure. Esthetic improvements were observed 12 months postoperatively (Figure 7b, 7c) and were maintained during 2 years of follow-up (Figure 8a). No scars were noticed. A full coverage of the recession, a gain of keratinized tissue and an increase in the tissue thickness were observed.

- Conclusion

Gingival recession is a common clinical observation. Underlying etiology and recession severity should always be investigated and addressed. Appropriate oral hygiene instructions should be considered. In cases where the recession is more significant, causing aesthetic concerns or ongoing problems with root hypersensitivity, surgical treatment should be recommended. Due to the highly specialized nature of minimal surgical procedures, the fact that root coverage procedures are very technique sensitive, patients requiring surgical correction of recession defects should be referred to a periodontist for management.

- References


Clinical Case after a 2-year follow-up in which a coronally advanced flap was used in combination with a subepithelial connective tissue graft and enamel matrix derivative (Straumann Emdogain®) to treat a single gingival recession.

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Clinical case after a 2-year follow-up in which a coronally advanced flap was used in combination with a subepithelial connective tissue graft and enamel matrix derivative (Straumann Emdogain®) to treat a single gingival recession.
Monolithic brothers

Fabricating individualized monolithic restorations using IPS e.max CAD LS₂ and Zenostar ZrO₂

By MU Dr. Petr Hajný, CZ

Patients who visit the dentist with the wish to have their smile enhanced would like this to happen in a fast, efficient and complication-free manner.

Esthetic and functional rehabilitations of anterior dental arch and occlusal height CAD lithium disilicate ceramics (LS₂) can be completed in a single day using IPS e.max® in combination with CAD/CAM technology (the CEREC system by Sirona, Germany, was used here). We use T-Scan® technology (Telescan, USA) to assess the articulation and this method has enabled us to achieve excellent results.

Until recently, closing lateral gaps in patients refusing to undergo implant treatment posed a problem with timescales for us. Zirconia bridges have become the solution for these cases. To be able to treat our patients within a few hours, but at the longest within 48 hours, we were looking for possibilities of speeding up, or simplifying, this treatment modality. After considering the results of scientific studies investigating the surface properties and wear of various polished monolithic ZrO₂ restorations, we decided that the Zenostar® CAD/CAM system from Wieland would be appropriate for this purpose. This system allows us to mill even extensive bridges from zirconia.

Case presentation

The patient in this case was a 60-year-old lady whose dentition had been restored with metal ceramic crowns in the anterior and bridges in the posterior region. Her main complaint was the colour and length of the teeth. Her teeth were completely invisible during both speaking and smiling (Figs 1 to 3). She wished to have a bright smile that was the colour of “Hollywood white”. She refused to have any implant therapy to close the gaps in the posterior region. For this reason, we chose to use all-ceramic bridges. The plan was to manufacture a bridge spanning from tooth 23 to 26, a cantilever bridge from tooth 35 to 33 with a pontic at 36 and a bridge from tooth 45 to 47.

The gingival tissues were in poor condition and this was mainly attributed to the impact of the metal ceramic restorations. Figure 4 shows the need for increasing the vertical dimension.

Material selection

On the basis of a pre-color shade guide, the patient decided in favour of the BL2 bleach shade and did not want this shade to be tuned down with materials of a darker hue. We therefore decided to use the unainted, or pure, shade variant for the fabrication of the ZrO₂ block.

The contours of the ZrO₂ bridges and IPS e.max CAD LT blocks in the BL2 bleach shade (Fig. 5). Usually, we use IPS e.max CAD for the fabrication of three-unit bridges up to the second premolar. The presence, however, required four-unit bridges and a cantilever bridge in the posterior region; IPS e.max CAD does not cover these indications.

Clinical procedure

After the existing restorations had been removed, FRC Postec glass-fibre reinforced composite root canal posts were inserted into teeth 21, 25, 35, 44 and 45, followed by the placement of MultiCore® Flow core build-up composite. Next, we replaced all existing single restorations with crowns made of IPS e.max CAD using the CEREC MCXL CAD/CAM system and IPS e.max CAD LT blocks in shade BL2 (staining technique). The occlusal height was raised at the same day and temporarily stabilized with Tello® CAD bridges. The lower anterior teeth were restored with laminate veneers made of IPS e.max CAD (staining technique). Prior to placing the Tello CAD bridges with Tello CS Link, impressions were taken (Virtuali® 300). A late record of the new vertical dimension as taken using Virtual CADBite silicone material. The bridges were manufactured using a Wieland® scanner and a Zenostar mini milling unit. The restorations were designed with Shapem® software (Figs 6 to 8). To reconstruct the bridge from tooth 23 to 26, the canine, the first premolar and the second premolar of the first quadrant were milled while the first molar was reconstructed on the basis of data retrieved from the Shapem library, (Figs 10 and 11).

Final seating

On the second day, the temporary Telio CAD bridges were removed and the teeth were cleaned with chlorhexidine-containing Cervitec® Liquid mouth rinse. Try-in was carried out without any problems; additional adjustments were not required. The restorations were cleaned with IvoHeal® and silanized with Monobond® Plus.

The preparations were pretreated with MultiLink® Automix Primer A + B and then seated using MultiLink Automix luting composite (yellow shade). After the luting composite had been pre-cured with a Bluemap® curing light and excess material removed, the restorations were permanently cemented in place activating the Turbo mode of the curing light a number of times. Articulation and occlusal contact points were assessed with a TeleScan device and then the occlusal surfaces were polished with the outcome. Her wish has been fulfilled.

Conclusion

A slight difference in brightness between the ceramic restorations, bridges and the IPS e.max CAD crowns can be noted. With hindsight, we would adjust the shade of the Zenostar framework with antagonists, we may conclude that we chose a functional and sensible solution [Enamel wear caused by monolithic zirconia crowns after 6 months of clinical use – T. Stober, J.L. Bermejo, P. Rammelsberg, M. Schmitter].

Fabricating individualized monolithic restorations using IPS e.max CAD LS₂ and Zenostar ZrO₂

Fig. 1. Before view of the lips
Fig. 2. OptraGate®
Fig. 3. Before lateral view with OptraGate
Fig. 4. Clinical situation after removal of maxillary crown
Fig. 5. Wieland work station and ZrO₂ block
Fig. 6. Design of the bridge 25 to 26 in the Sshape software
Fig. 7. Design of the cantilever bridge from tooth 33 to 13 with a pontic at 16 and a bridge from tooth 41 to 47
Fig. 8. Virtual articulation to establish the functional characteristics
Fig. 9. Final seating
Fig. 10. Monolithic restorations after eleven months: IPS e.max CAD restorations and Zenostar Zr
Fig. 11. Anterior view of the rehabilitation
Fig. 12. View of the lips: The patient is pleased with the outcome. Her wish has been fulfilled.
Fig. 13. Close-up of the monolithic IPS e.max CAD crowns fabricated using the staining technique

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DENTAL TRIBUNE Middle East & Africa Edition | July-August 2015

32 CAD/CAM
Giving Patients Rolls Royce Treatment

By Dental Tribune MEA/CAPP/Peren

Dubai, UAE: From the tallest building in the world, the largest shopping mall across the globe, to building the first 3D printed office, Dubai is known for setting records. When it comes to Same Day Dentistry, Dr. Costa & Dr. Petros (SameDay Dental Implants Clinic, Dubai) is now offering the first Rolls Royce chauffeur complimentary service to its patients.

SameDay Dental Implants Clinic is located in the heart of DHCC, specializes in dental implants and same-day teeth. Co-founders Dr. Costa and Dr. Petros were recently inspired by Dubai Police. With a vast fleet of sports cars straight out of a “Fast & Furious” movie the Dubai Police lineup includes a Ferrari, Veyron Bugatti, Aston Martin, Lamborghini and even a McLaren. “We said, why not do that as well?” — commented Dr. Petros.

The clinic recently purchased the exquisite Rolls Royce Ghost model to cater to its patient’s before and after treatments.

Dr. Costa and Dr. Petros for over 20 years have adapted the pioneering technique of the late Professor PI Branemark, the Swedish founder of dental implantology who first introduced the concept. Normally, implant treatments can take up to six months to complete. SameDay Dental Implants (a state-of-the-art specialist dental clinic), known as the first in UAE to offer patients a complete teeth implant procedure in five to six hours has now taken its customer service to the next level. “I believe we are in the right place to offer such a luxury treatment. Obviously we do not provide the Rolls Royce for consultations as everybody would like to have a ride, however we do transport two to three patients a day for immediate loading treatments, which have a 98% success rate. The chauffeur service is offered to our patients who are picked up either from the airport, hotels or anywhere in the United Arab Emirates as a matter of fact.” — Dr. Costa comments.

“One year ago, we had a consultation around 6 in the evening all the way from Abu Dhabi. We said, you need to remove all your teeth, because they are moving, and place implants. His reply was, I wish I could do that right away. So we told him, be careful what you are wishing for, we can do that right now for you and then take you home in the Rolls” — Dr. Petros further explains.

SameDay Dental Implants Clinic is built on the principle of bringing a smile fast to people who value their time. With the renowned services offered in the UAE, Dr. Costa and Dr. Petros have now found a way to be the first to make their patients smile before and after their implant treatment. What better way to make the patient more comfortable than sending out the Rolls Royce Ghost to collect the patient and then take him back home again.

“The whole team at SameDay Dental Clinic is focused on providing excellence and award winning services under one roof. Patient care and comfort is at the heart of everything we do. The chauffeur service combined with everything that Rolls Royce symbolizes is an extension of that. Our patients really enjoy this new added value service as it makes their SameDay Implant treatment so much comfortable and convenient” — said Dr. Costa.

Top notch service provided by the SameDay Dental Implants Clinic Team led by Dr. Costa and Dr. Petros

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DON'T MISS!
Versailles Dental Clinic, expanding from the dental to the medical

By Versailles Dental Clinic

Dr. Dominique Caron did just that with Versailles Dental Clinic. The concept of One Session Dental Solutions is revolutionary and matches with the demands of the market. His professional skills complimented with the innovative technology sealed the deal and the clinic became one of the flagship dental institutions in the UAE.

Taking into the account that the growing healthcare sector in the Middle East is set on a drastic upward expansion in the next 5 years, Dr. Dominique and his wife, Veronique Caron are inaugurating in September 2015 Versailles Medical Clinic in Dubai Healthcare City.

Versailles Medical Clinic, what to expect?

The mark of excellence, of course. Dr. Caron handpicked the best European doctors. Versailles Medical Clinic’s team includes a General Practitioner, Aesthetic Specialist, Gynecology and Pediatrics. The vision of the medical center is to become the leading medical center in Dubai that will represent the benchmark for medical excellence in the UAE. Is it too ambitious? Not quite. Versailles Dental Clinic has proven that Middle East is a mature market and is ready and demanding in fact medical excellence and VMC will use the same blueprint.

Location and opening dates

Versailles Medical Clinic is an organic extension of Versailles Dental Clinic and is located next door at Al Razi Building 84, Block A, 1005, Dubai Healthcare City, Dubai. The official opening is set for September 2015, watch this space for further announcements.

We look forward to welcome you in a true Versailles style, for further inquiries drop us a line at info@versaillesdentalclinic.com.

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** Prices for 2 issues/year are €22 and €23 respectively per year.

New Colleague

By Versailles Dental Clinic

As Versailles Dental Clinic is ever evolving, we are happy to announce that Dr. Albert Sarrio, General Dentist, Implantologist joined Dr. Caron’s team.

He is a very passionate dentist dedicated to achieving the best, healthiest, and most beautiful smiles for his patients.

After receiving his degree from University of Barcelona in 2007 he attended the prestigious Paris University XII and got his Master Degree in Oral Rehabilitation and Implantology in 2010. He specializes in dental implants and CBCT CAD-CAM prosthodontic treatments.

Dr. Sarrio’s philosophy is that the first step in achieving optimal personal wellbeing is maintaining impeccable oral health. Dr. Albert chose to join Dr. Dominique Caron as his expertise matches with the world-wide recognized quality of dental treatments offered at Versailles Dental Clinic Dubai.

Dr. Sarrio, who also enjoys football and cooking, is a student of life as well. He is constantly learning, and researching different topics, especially those that relate to helping us achieve optimal health, and having that improve our everyday life.
Introducing the Inman Aligner

By Inman Aligner

Until now, the alternatives to straighten front teeth involved either long and expensive orthodontic treatments or destructive and expensive restorative treatments such as veneers or crowns. Even ultrathin veneers involve heavy reduction of natural teeth when used to align crowding or protrusion.

But with the arrival of the Inman Aligner, all that has changed.

The Inman Aligner is a cost-effective removable orthodontic appliance that moves teeth in a fraction of the time of other systems. It aligns crowded or protruding anterior teeth with two opposing spring loaded aligner bars. This provides gentle but continuous pressure over a large range of movement. Surprisingly, this gentle pressure is the quickest way to move teeth but it also makes treatment very safe and kind to teeth.

People love the speed of treatment and it’s changing the face of dentistry as we know it. The average treatment time is only 4-16 weeks and now with concerns over the economy it’s a more justifiable expense.

“The Inman Aligner is the greatest innovation in dentistry of recent years. It’s fast, affordable and kind to teeth. It really is the best way to straighten crowded front teeth.” – Dr. James Russell, UK

Only certified Inman Aligner dentists can provide them. Make sure you become a certified Inman Aligner dentist at the upcoming 7th Dental Facial Cosmetic International Conference where the Inman Aligner Symposium will be held as a joint event. Basic and Advanced Inman hands on courses are available.

More Information


New

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DUBAI, UAE: Known for treating the likes of Donald Trump, Lea Michele, Uma Thurman and Matt Dillon to name a few, Dr. Michael Apa has now opened his private clinic in Dubai. After spending 6 years as a visiting doctor in the MEA region treating royal families, the Apa Aesthetic Dental & Cosmetic Centre in Jumeirah is already running at full capacity.

Dental Tribune MEA: Dr. Apa, we appreciate the opportunity for this interview. You have been quite active in the Middle East prior to the opening of your new Clinic – Apa Aesthetic Dental & Cosmetic Centre this year in Dubai. Could you elaborate on your experience in the region and the ideas behind starting the clinic in Jumeirah?

Dr. Michael Apa: I have been coming for over 6 years now with a growing demand from patients wanting to be seen. It was the next logical step to open something of my own. Although being a visiting doctor had its simplicities, there is nothing quite like managing your brand with your own clinic. From choosing the staff, doctors, clinic feel and how it is run, it is really the only way.

What separates the Apa Aesthetic Dental & Cosmetic Centre from the hundreds of clinics in Dubai?

Well, that is tough to answer. We have spent a lot of time with design of the clinic, understanding what the patient truly needs, trying to eliminate the feel of “dentsity.” We did the obvious things like create a flow that offers both an excitement for the patient coming in, how we designed the waiting room and front desk to also creating a sub wait room for privacy and a VIP operator up stairs away from the rest. We put music throughout to drown out stairs away from the rest. We put music throughout to drown out

An International Brand

Dr. Michael Apa has built a brand of himself in the United States of America and is now doing the same in the Middle East. First stepping foot in 2008, Dr. Michael Apa had no idea what was to follow of his journey to the Middle East. With the fast spread of information, he soon found himself treating the Gulf’s most influential individuals including the Royal Family. By recognizing a gap in the patient care in Dubai, the first stages of the treatment plan were digital. Setting up pre-screening appointments where patients entered the existing office in Dubai, have their records taken and scheduling virtual appointments with Dr. Michael in New York City. After the details were finalized, Dr. Apa would make his way to Dubai for the treatment.

Dr. Michael Apa has now opened his private clinic in Dubai. After spending 6 years as a visiting doctor in the MEA region treating royal families, the Apa Aesthetic Dental & Cosmetic Centre in Jumeirah is already running at full capacity.

What treatments does the clinic offer?

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What is your favorite part of the clinic?

The patient’s response to the care we have provided them with. To see the patient’s smile after a procedure is completed is always the best.

What is your advice for patients of yours who are coming from the MEA region to Dubai for treatment?

It is always worth mentioning that in Dubai, we have a top-notch facility but we also have a top-notch staff that is also trained by me and my New York team. We are a world-class practice.

Aesthetic Dental & Cosmetic Centre in Dubai, UAE.

By Dental Tribune MEA/ACP/Mona

About Dr. Michael Apa

Dr. Michael Apa is an assistant Clinical Professor at the Aesthetic Department in the New York University College of Dentistry and Senior Clinical Director Aesthetic Advantage Continuing Education Program in New York, Palm Beach and London. Dr. Apa lectures nationally (USA) and internationally and is a member of the American Academy of Cosmetic Dentistry, American Dental Association, Academy of General Dentistry and has received the 2007 ACD Cosmetic Dentistry Award for outstanding performance in the first five years of practice. His excellence service to VIP’s and Royalty have been rewarded by the award of the American Academy of Hospitality Services Five-Star Diamond Award. Dr. Michael Apa is the owner of Roseenthal-Apa Group in New York City and private owner of the Apa Aesthetic Dental & Cosmetic Centre in Dubai, UAE.

From treating Hollywood celebrities to Royalty in the Gulf

**An attractive smile is the centerpiece of Facial Beauty.**

- Dr. Michael Apa, USA

Dr. Michael Apa, USA is known for treating celebrities across the world.

**About Dr. Michael Apa**

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**What is your advice for patients of yours who are coming from the MEA region to Dubai for treatment?**

It is always worth mentioning that in Dubai, we have a top-notch facility but we also have a top-notch staff that is also trained by me and my New York team. We are a world-class practice.
We are a full service clinic with an accent on aesthetic dentistry. We do hygiene, porcelain fillings, crowns, veneers, implant surgery, grafting, you name it.

With such a busy schedule, how do you stay up to date in the field of dentistry? Are there any courses, conferences and programs which you follow in the region or are they mostly back in the USA?

Fortunately I am also on the lecture circuit, which puts me in at least 10 major conferences a year with top speakers from all over the world. Not only will I watch their lectures, but would be able to collaborate as well as to what everyone is doing.

The region has seen you lecture at various events such as the Current Concepts in American Dentistry NYU and the Dental Facial Cosmetic Int’l Conference. What are some of the hot topic concepts which you speak about during your lectures?

I typically speak about facially generated treatment planning and multi-disciplinary aesthetic treatment.

How do you rate the level of dentistry in the Middle East? Do you see areas which need major improvement?

It is unfair for me to say one way or the other because I haven’t seen enough of it to make an opinion, but in today’s world of online education, I see no reason why it should be any different than any other place. The Middle East has every opportunity to be great just like the rest of the world. In fact, I personally have given many lectures in the Middle East over the years.

Dr. Michael Apa, thank you for your time and we Dental Tribune MEA wishes you all the best with your practice in Dubai.

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Facial Aesthetic Design (FAD)
Dr. Apa has created the concept of Facial Aesthetic Design (FAD) – a minimally invasive method that is constantly being evolved and taught to other professional dentists across the world. The 465 square metered Apa Aesthetic Dental & Cosmetic Centre in Dubai is one of the first aesthetic dentistry practices featuring a state-of-the-art lab on-site.
The 1st Dental Business Management Conference in the UAE – how did this happen?

By Eniko Simon

The 1st Dental Business Management Conference in the UAE was held in Dubai on Friday 12th June, 2015. I am still amazed and extremely excited about the event – it is unbelievable we actually created this event out of passion, dedication and enthusiasm. The idea was to create a unique event in the UAE that approaches dentistry from a different angle – business management.

I have been working in the dental business for eight years now in the UK and in Dubai as a clinic manager before setting up my business to offer consultancy services and provide business management training, specifically for dentists and clinic managers in the UAE. I could see the great need to provide a conference where we view dentistry as a business. Many dentists leave dental schools and one day they decide it’s time to open their own clinic. Unfortunately, not all of them will have the skills required to be successful. They have the clinical knowledge but lack the business knowledge as clinic management is still a grey area in dental universities.

I carefully selected the speakers to make sure that we covered diverse areas of Dental Business Management. I talked about communication, ethical sales in dentistry and the role of a treatment coordinator. We had Fiona Stuart-Wilson who was talking about how to gain competitive advantage in dentistry. Karl Taylor-Knight was talking about a 21st century marketing approach in dentistry and Dr. Ehab Heikal discussed Quality Control. All the speakers were outstanding – great subjects and great interaction with the delegates.

The positive feedback from the delegates gave the reassurance that it was worth every minute of the hard work that has been put into organising this event. The enthusiasm and engagement from the delegates was extremely rewarding. We did something that had great value. Delegates went home with ideas, tools and techniques that will help them to manage their clinics more efficiently by implementing the new ideas, tools and techniques.

Our goal with this event was to test the waters to see if there is enough interest in an event like this. I have to say we could have not dreamed of a better outcome. The event proved that clinic owners and managers are very keen to gain more knowledge. They do realise how important it is that they manage their dental clinic in a more structured and efficient manner. We had 35 delegates coming for this event from all over the middle east included Saudi Arabia, Kuwait, Lebanon and of course from the UAE.

We will not stop here – this is just the beginning! We have amazing ideas. We have already started to work on our next conference in 2016 which will be even bigger and better!!

In addition, we will be running our dental business management courses and treatment coordination courses in October 2015. We know the need is there. We want to provide support to those clinic managers and owners who have a hunger for the knowledge and who wish to gain competitive advantage in this very competitive market. We want to enable them to manage their dental business more efficiently and effectively.

Contact Information

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The seven essential habits of dental leaders

By Fiona Stuart-Wilson

I f you are running a practice it can be too easy to get tied up in the day to day activities of getting from the beginning of the day to the end, and forget to focus on a very important key to the success of your practice -- yourself. Whether you are new to management and leadership or have several years of experience in running your practice it's important to take charge of your own development in this area to ensure that you are as effective as possible in leading and managing your team and your practice.

Leadership or management? There is constant debate over the difference between leadership and management. Some would suggest that managers plan, organize and coordinate, whereas leaders are expected to inspire and motivate. In reality in the daily life of dental practice dentists have to do both.

Habit 1 – Think like a leader

Successful leaders are critical thinkers; they ask why things happen, and come up with ways for avoiding and preventing problems before they arise. Similarly they can see potential opportunities and take advantage of them to benefit their practice.

Habit 2 – Embrace change

A hallmark of a leader is not that they keep the practice running smoothly but that they act as an agent of change and improvement. Turn an inquiring mind on how you could do things better and differently, not only in areas which you feel need improvement but also in other areas which are going well. Take a step back from what you are doing day to day and consider to improve the way the things are done. What are the advantages of changing things? What are the disadvantages and are they outweighed by the benefits?

Habit 3 - Be disciplined

Leadership can be lonely. Good leaders recognize too that they don’t know everything. Many leaders recognize that they have had a bad weekend or problems at home. Your staff should not be able to tell that you have yourself out. Address is- sues and goals, and explore ways of resolving or reaching them.

Habit 4 - Listen actively

One of the most important skills for any leader is the ability to listen. By doing this they can get feedback from others and tap into the knowledge, experience and views of team members.

Habit 5 - Learn to handle conflict and make decisions

A hallmark of a leader is not that they keep the practice running smoothly but that they act as an agent of change and improvement. Turn an inquiring mind on how you could do things better and differently, not only in areas which you feel need improvement but also in other areas which are going well. Take a step back from what you are doing day to day and consider to improve the way the things are done. What are the advantages of changing things? What are the disadvantages and are they outweighed by the benefits?

Habit 6 - Motivate others

Good leaders notice the little things. They influence people in a positive way. When members of a team or indeed an entire team lose their drive and passion for what they do, an effective leader can detect a flagging team and energize and motivate individuals to regain their passion for what they do. This means taking time to value and recognize people's contribution to the practice.

Habit 7 - Use a mentor

Leadership can be lonely. Good leaders recognize too that they don't know everything. Many identify and learn from a mentor who can help them develop their ideas about management and work through their particular leadership issues. Mentors will not tell you what to do but should help to motivate and empower you to identify your own issues and goals, and explore ways of resolving or reaching them.
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The Ten Commandments of Customer Service

By Ehab Heikal

The People aspect of business is really what it is all about. Rule #1: Think of customers as individuals. Once we think that way, we realize our business is our customer, not our product or services. Putting all the focus on the merchandise in the services our clinic offers, leaves out the most important component: each individual customer.

Keeping those individual customers in mind, here are some easy customer service tips to keep them coming back!

1. Remember there is no way the quality of customer service can exceed the quality of the people who provide it. Think you can get by paying the lowest wage, giving the fewest of benefits, doing the least training for your employees? It will show. Clinics don’t help customers, people do.

2. Realize that your people will treat your customer the way they are treated. Employees take their cue from management. Do you greet your employees enthusiastically each day; are you polite in your dealings with them; do you try to accommodate their requests; do you listen to them when they speak? Consistent rude customer service is a reflection not as much on the employee as on management.

3. Do you know who your customers are? If a regular customer came in to your facility, would you recognize them? Could you call them by name? All of us like to feel important; calling someone by name is a simple way to do it and lets them know you value them as customers.

4. Do your customers know who you are? If they see you, would they recognize you? Could they call you by name? A visible management is an asset. At some clinics, the picture of the entire clinic team is placed near the reception stand or in the waiting area, in full view of the customers. The manager is easily accessible and there is no doubt about “who’s in charge here”. You have only to beckon to get a manager to talk with you.

5. For good customer service, go the extra mile. Include a thank-you note in a customer’s Rx, or in your next visit’s card; clip the article when you see their name or photo in magazine or newspaper write a congratulatory note when they get a promotion. There are all sorts of ways for you to keep in touch with your customers and bring them closer to you.

6. Are your customers greeted when they walk in the door or at least within 30-40 seconds upon entering? Is it possible they could come in, look around; and sit down without ever having their presence acknowledged? Could it be that’s because Sam Walton (CEO, Wal-Mart) knew this simple but important gesture is a matter of respect, of saying “we appreciate your coming in,” having nothing to do with the amount you pay?

7. Give customers the benefit of the doubt. Proving to him why he’s wrong and you’re right isn’t worth losing a customer over. You will never win an argument with a customer, and you should never, ever put a customer in that position.

8. If a customer makes a request for something special, do everything you can to say yes. The fact that a customer cared enough to ask is all you need to know in trying to accommodate him/her. It may be an exception from your customer service policy, but (if it isn’t illegal) try to do it. Remember you are just making one exception for one customer, not making new policy. Mr. Marshall Field was right on in his famous statement: “Give the lady what she wants.”

9. Are your customer service associates properly trained in how to handle a customer complaint or an irate person? Give them guidelines for what to say and do in every conceivable case. People on the frontline of a situation play the most critical role in your customer’s experience. Make sure they know what to do and say to make that customer’s experience a positive, pleasant one.

10. Want to know what your customers think of your clinic? Ask them! Composite a “How’re We Doing?” card and leave it at the reception or waiting area, or include it in their Rx or invoice. Keep it short and simple. Ask things like: what it is they like; what they don’t like; what they would change; what you could do better; about their latest experience there, etc. And if the customer has given their name and address, be sure to acknowledge receipt of the card.

Remember that the big money isn’t as much in winning customers as in keeping customers. Each individual customer’s perception of your company will determine how well you do this and that perception will depend on the level of customer service you provide.
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Recommend Sensodyne – specialist expertise for patients with dentine hypersensitivity

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Appreciation for the support to Dr. Nabeel Hamoodi Alshabeeta, Ministry of Health UAE

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Appreciation for the support to the Lebanese Dental Association represented by Dr. Tony Dib, Dr. Nadim Abojaoude and Dental News represented by Dr. Tony Dib.

Thank you to Mr. Abdo Salem and Amann Girrbach for the continuous support over the years.

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Delegates enjoying the splendid lunch at Jumeirah Beach Hotel
Infection control in dentistry has never been more essential

By Dental Tribune International

Demand for dental treatment has been increasing in recent years as people have become more aware of their oral health and the benefits of good dental aesthetics. Maintaining and practicing stringent cross-infection control procedures therefore have never been more essential to ensure the health and safety of dentists, dental hygienists and assistants, as well as other supporting staff who may be indirectly involved in the treatment process.

Dental professionals are at high risk of cross-infection. A report published in 1996 has shown that in developing countries, for example, the number of dental staff contaminated during treatment is increasing by almost 6 per cent each year.\[1\] Research has shown that infectious micro-organisms can be transmitted by blood or saliva via direct or indirect contact, aerosols, or contaminated instruments and equipment.\[2\]

As stated by the US Centers for Disease Control and Prevention (CDC) in their 2003 guidelines, the transmission of infectious disease can occur in four ways: direct contact with blood or body fluids, indirect contact with contaminated objects or surfaces, contact with bacterial droplets or aerosols, and inhalation of airborne micro-organisms.\[3\]

The most likely mode of transmission in dentistry is through inhalation of bacterial aerosols or splatters. Their potential health hazards are well documented and acknowledged.\[4–8\] Both can be host to a large variety of micro-organisms and viruses, which can be infectious to susceptible individuals. During treatment, the dentist’s face and patient’s chest are most affected by splatter, as the majority of the splatters are radiated towards them.\[8, 10]\n
According to studies, the most contaminated area on the dentist’s face during treatment is around the nose and inner corner of the eyes.\[9\]

Splatter consists of large particles of greater than 100 µm generated during the use of dental equipment, such as turbines, ultrasonic scalers, or water and air syringes. Owing to this, splatter tends to travel in a trajectory, thereby contacting objects in its path. Aerosol consists of smaller particles

Higher caregiver education level linked to fewer cavities in children

By Dr. Safura Baharin, Malaysia

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By Philips

Dental Tribune

hygiene tribune

Dental Tribune Middle East & Africa Edition | July-August 2015

Philips Sonicare DiamondClean; Product of the Year Winner in the Oral Care Category in the GCC Countries

DUBAI, UAE - Philips is proud to present that the Sonicare DiamondClean has been elected Product of the Year in the oral care category. The independent survey was conducted among 3,600 consumers in the UAE, among the most valued awards in consumer perception of products.

Sonicare DiamondClean takes sonic tooth brushing to its most sophisticated level and wins in delivering Sonicare’s best clean yet removing up to 100% more plaque in hard to reach places than a manual toothbrush.

Sonicare DiamondClean harnesses Philips Sonicare’s patented sonic technology to provide a deep, thorough clean that delivers Sonicare’s best clean yet removing up to 100% more plaque in hard to reach places than a manual toothbrush.

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Sonicare DiamondClean takes sonic tooth brushing to its most sophisticated level and wins in delivering Sonicare’s best clean yet removing up to 100% more plaque in hard to reach places than a manual toothbrush.
The Ultimate Sonicare Power Toothbrush

Winner in the Oral Care Category

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Toothbrush developments. Oral health benefits

PPD hears from Procter & Gamble researcher Karen Claire-Zimmet about the ground-breaking advances behind the Oral-B CrossAction toothbrush

By Karen Claire-Zimmet MS BS

Toothbrush research and development combines science, technology, and art. Optimising toothbrush performance involves several disciplines including an understanding of mechanical systems, filament properties and physics, production technology, and in addition ergonomics and human behaviour via consumer research. This combination of efforts has yielded toothbrushes that significantly contribute to improvements in the oral health of the population.

The modern toothbrush has its origins in primitive designs (Figure 1) that had large brush heads with straight, hard and abrasive boar’s hair bristles. In the early 1900s, the first Oral-B manual brush (Figure 2) was developed with multifilament nylon filaments that were flattened, vertical, and end-rounded for safe brushing. This was the first modern toothbrush design and similar designs are still in use globally. The full importance of brush head morphology and bristle configurations had yet to be discovered. Before that could happen, and more effective designs could be developed, it was necessary to fully understand the basic fundamentals and cleaning mechanisms of the individual elements that make up a toothbrush.

Understanding the fundamentals

In order to gain a thorough understanding of toothbrushes and what defined toothbrush success or failure, our team used the power of observation and created a defined problem statement: how can we maximise toothbrush bristle contact interdentally, for improved cleaning and oral health? By breaking down this problem statement into more basic elements, we were able to gain that understanding. Although toothbrushes may appear simple, they are actually quite complicated. As with complex chain molecules that consist of basic chemical elements, at Oral-B we broke down toothbrush mechanisms and design into basic physical elements.

We developed our knowledge base by transitioning from what one could call a ‘macroscopic’ perspective to a ‘microscopic’ perspective on the variables that affect toothbrush efficacy and use, first examining brush heads, then tufts of bristles and then individual filaments. Our research needed to address how tufts behaved during use; how individual filaments moved and behaved; what influence usage had on tuft and filament direction and movement, and how this influenced plaque removal efficacy.

Other basic elements that required research included discovering which factors determine the ability of a single bristle/filament to penetrate interproximally, as well as the influence of filament and tuft length, width and shape. I had studied physical chemistry during my masters degree studies - specifically, polymer dynamics using techniques of light scattering and Fourier transform analysis to understand the time dependence of polymer behaviour. The leap from polymer dynamics to toothbrush bristle behaviour, particularly the ability and time dependence of filaments reaching interproximally, is not as large as one might first think.

More fundamentally, we further needed to thoroughly understand how consumers actually brushed - for instance, we found that a basic horizontal scrubbing motion (rather than a modified floss technique) was used most often by consumers.

All of this was crucial knowledge - only after gaining an understanding of how consumers really use our products would we be able to improve the design of a toothbrush to work most effectively with common brushing techniques used by consumers.

A Journey of Discovery

Our basic filament dynamics research led to a better understanding of the influence of bristle/filament angle and diameter, and the applied brushing load on bristle penetration. I led the filament research, which included creating an experimental setup with a model dentition to enable us to study the ability of filaments to reach interproximally (Figures 3-5).

Our hypothesis was that filaments bent towards the direction of travel would be more likely to enter the interproximal gap. From our observations, it became clear that when a bristle is positioned perpendicular to the tooth surface it tends to bend away from the direction of toothbrush motion and is therefore less likely to penetrate between the teeth. This means that a filament is actually most actively cleaning during directional changes of brushing. As a result brushing motion close to an interproximal site reach the area most effectively during these directional changes; more distant filaments have already changed their direction of travel by the time they reach the interproximal site. Filaments angled at <12º still tend to bend away from the direction of travel and are unable to reach interproximally (Figure 5). However, we were able to demonstrate that filaments at >12º angles are able to effectively maintain their position, facing towards interproximal sites, first reaching within the interproximal space before then bending away from the direction of travel while still in the interproximal gap (Figure 6). Taking a more macroscopic view of the brush design, including evaluating different filament shapes and heights - we found that, thinner filament tufts are better able to reach interproximally while shorter, thicker filament tufts are superior for flat tooth surfaces.

We also discovered that if too much load (brushing pressure) is applied to individual bristles that they collapse and cannot enter the interproximal gap. Conversely, if too little load is applied, the bristles may ‘skip’ over the gap and miss their target. These were key learnings in defining what the final tuft density of the Crossaction design would be.

Key Learnings

- Angled bristles (>12º) are superior in reaching interproximal sites
- Longer, thinner bristle tufts are more effective interproximally
- Shorter, thicker bristle tufts are more effective on accessible surfaces
- Filament packing density influences brushing load on individual filaments and, correspondingly, the ability of bristles to contact and clean sites

The Outcome: CrossAction

The first time we tested an early prototype design of the CrossAction toothbrush in our performance laboratory we could not believe its cleaning performance, it was so good. We literally recalibrated the test and analysis equipment, to make sure there were no errors in the analysis and to confirm the calibration. We had never seen anything that performed so well, the results were off the chart!

The result of our research was a shift in the art and science of making toothbrushes, and a novel manual toothbrush design that was based on an understanding of the superiority of angled filaments as well as the importance of filament sizes and shapes, and directional change. The CrossAction toothbrush has bristle tufts with a 16º angle to the brush head in both directions, as well as tall, thin, elliptical bristle tufts supported by dense neighbouring tufts that decrease interference between bristles (Figure 7). Its design increases bristle contact with the tooth surface and improves approximate reach during brushing, both of which lead to greater plaque removal efficacy.

The effectiveness of CrossAction in interproximal reach, and related improved plaque removal, was initially demonstrated in laboratory studies and the findings were confirmed in clinical trials. Laboratory research published in 2000 demonstrated significantly greater plaque removal for CrossAction relative to 84 manual toothbrushes found in global field tests. Subsequent clinical trials, including single-use and long-term studies, corroborated the in vitro data.

CrossAction was shown in numerous clinical trials to provide superior plaque removal and gingivitis benefits versus not only various manual toothbrushes, but also battery-powered toothbrush models.

An important observation and outcome was the response of people testing the CrossAction toothbrush, as well as the reaction of dental professionals. People loved the CrossAction - they could feel a difference and intuitively understood that angled bristles would be able to reach between the teeth more effectively. After testing it, they did not want to give it back.

At the time of its development, the CrossAction was impossible to make with existing brush-making equipment, due to the angled bristle design and very high bristle packing densities. Making the
HEALTHIER & STRONGER TEETH* STARTING FROM DAY 1
WITH CONTINUED USE

*ON ENAMEL PLAQUE AND ENAMEL EROSION VS ORDINARY TOOTHPASTE

Toothpaste from the No.1 toothbrush brand used by dentists themselves worldwide
How implant prosthetic design influences implant maintenance access

By Shirley Branam, USA and Gerhard Mora, USA

Achieving a balance between implant-support ed restoration esthetics and maintaining periodontal health is important in an overall successful outcome of the prosthesis. The goal is to create an emergence profile design that allows for minimal tissue displacement while achieving optimal cervical contours for esthetics. It is important in the design to allow access for proper cleaning by the patient and clinician (Fig. 1).

There are two types of implant restoration designs commonly used in single-tooth replacement prosthetics. They are a screw-retained crown or a two-piece abutment and cement-retained crown. The screw-retained crown design is the technique more commonly used in Europe, whereas the cement retained crown prosthetic design is currently used in the United States.

The screw-retained restorations contain a small chamfer access hole where the screw retaining the restoration is inserted. The crown is screwed directly into the implant and the access chamfer is typically closed with a tooth-colored resin (Sarmont, 2000). There are a few advantages to this restoration design. First, since cement is not used in this method, the opportunity for subgingival residual excess cement to remain on the prosthesis cannot occur. When excess cement is left, it can create the opportunity for inflammation and peri-implantitis to develop in the implant sulcus. Second, the screw can be easily removed from the restoration, allowing for crown removal if necessary during any maintenance procedures.

The two-piece abutment and cement-retained crown restoration has an abutment that is designed to provide the subgingival emergence profile and allows for easy cement removal over the abutment (Fig. 2). The emergence profile refers to the subgingival contours that lie between the implant platform and the emergence abutment and crown (Sarmont, 2009). Using a custom designed abutment provides greater predictability in determining the proper shape of the emergence profile compared with pre-fabricated standard abutment design.

To obtain a pleasing restoration, the subgingival contours must start at the small circle of the implant head and emerge from the tissue with an anatomical profile (Sarmont, 2009). The result should be an emergence profile that allows for minimal displacement of the surrounding tissue while creating an esthetically pleasing appearance. (Fig. 3). This design allows for easy access into the implant sulcus area so cleaning and maintenance can be easily achieved by both the patient and the clinician. Over or under contouring of the abutment and/or restoration can result in biofilm accumulation and peri-implantitis. It is important for the emergence profile to resemble that of a natural tooth. Often the adjacent teeth can be used as a guide to determine the proper contours.

The protocol for margin location of a standard implant restoration is still under debate. As the location of the crown abutment margin is placed deeper subgingivally, the ability to access and maintain the site becomes more difficult (Linkevicius, 2012). Care must be taken for placement of an adjacent crown to allow for the clinician and patient to maintain the implant. Access to the subgingival area of the implant prosthesis for proper maintenance is vital to the health and success rate of the prosthesis. As margin location and emergence profiles extend further subgingivally, the ability to maintain these sites becomes more challenging. Evidence has shown that power scalers with nonmetallic tips can be beneficial in maintaining the implant prosthesis (Sato, 2004). Several manufacturers offer tips designs that will accommodate the different types of power scalers. DENTSPLY Professional has an insert whose unique design allows for the use of a polythene sleeve to be assembled to the active tip area of this ultrasonic implant insert (Fig. 4). When fully assembled, the Cavitron® SoftTip™ Ultra sonic Implant Insert can easily be incorporated into a clinician’s implant maintenance procedure.

Incorporating ultrasonics scaling into the implant maintenance protocol may have several benefits. Combining mechanical movement and lavage can aid in the removal of biofilm and other debris in the implant prosthesis sulcus. Wilkins wrote in 2012: “Studies indicate cavitation is capable of destroying surface bacteria and can remove endotoxin from the root surface.” And: “Oscillation of the ultrasonic tips causes hydrodynamic waves to surround the tip. This acoustic turbulence is believed to have a disruptive effect on surface bacteria” (Wilkins, 2012). Multiple in vitro studies have discussed that cavitation may have the potential to disrupt the cell wall of the bacteria, and acoustic turbulence is believed to have disruptive effect on the surface bacteria (Baehni, 1992; Mc.

Innes, 1995; Walsdoy, 1999). However, further in vivo studies need to be conducted to determine if the same outcomes are achieved in the sulcus.

Another benefit to incorporating power scaling into the maintenance procedure is the ability to adapt the active tip area into the implant sulcus. Incorporating vertical adaptation of the active tip, at a zero to 15-degree angle, to the implant restoration can allow for significant subgingival surface contact for efficient deposit removal. When the emergence profile follows the anatomical shape of a natural tooth, this instrumentation technique can be an effective method of maintaining the site.

Finally, easy access for the patient is extremely important in the success of the implant prosthesis. There are a variety of interdental brushes, cleaners, and floss options available to the patient; it is important for the cleaners be easy to use, not cause tissue trauma in the implant sulcus, or surface damage to the esthetic materials in the restoration.

Dental implants are increasing in demand in part by their high success rates and the improved esthetics they provide the patient. A key to this success is having the proper design incorporated into the implant station. When designed properly, the implant restoration can be easily maintained by both the patient and clinician.

References


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Fig. 1: Emergence profile and crown should resemble that of a natural tooth so the patient and the clinician can achieve a balance between implant-supported restoration esthetics and maintain periodontal health.

Fig. 2: Custom abutment and crown design.

Fig. 3: Ideal subgumal formation created by proper emergence profile of the implant abutment

Fig. 4: Custom SoftTip Ultrasonic Implant Insert (Photo/Provided by DENTSPLY Professional.)

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About the Author

Karen Claire-Zimmer MS BS She is a senior scientist at The Procter & Gamble Company. She began her career in oral care research and development with Oral-B in the late 1980’s after receiving her master of science (MS) degree in physical chemistry from Stanford University, and her bachelor of science (BS) degree in chemical engineering from Birmingham University, New York. Karen has applied insights from her oral care research and development work such as that developing a host of both manual and power toothbrush designs and patents for numerous oral care patents.

Visit: dentalcare.co.uk

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Inspired by nature. Ivoclar Vivadent launches new SR Vivodent S PE tooth line

By Ivoclar Vivadent AG

COLOGNE, Germany/SCHAAN, Liechtenstein:
Nature creates the most beautiful shapes and shades and these have guided the design of the new anterior moulds SR Vivodent S PE, a further development of a long-standing, successful tooth line. Esthetically and prosthetically optimized, these moulds are designed to meet the individual requirements of today’s and tomorrow’s patients.

SR Vivodent is a distinctive anterior tooth for sophisticated needs. High shade intensity and PE layering lend these teeth an especially vibrant appearance. Together with the equally new SR Orthotyp S PE tooth line, they form a comprehensive range of denture teeth that offer a maximum degree of individuality.

Vibrant shades
The shade range of the new tooth line comprises 20 shade nuances. The shade intensity, brilliance and transulcency of these sophisticated PE shades closely imitate the shade of natural teeth, resulting in dental prostheses that harmoniously blend into the existing dentition. The portfolio is complete with a multifunctional shade guide. This guide assists users in determining not only the tooth shade but also the tooth size and lip closure line. This has been achieved by integrating the facial meter and papillameter into the design of the guide.

Matching posterior moulds
The new posterior moulds SR Orthotyp S PE ideally complement the new anterior teeth. They are designed on the basis of a detailed functional analysis of the stomatognathic system. With their refreshed modern appearance, the posterior moulds meet the high demands placed on the esthetic and functional characteristics of dental prostheses.

Highly cross-linked DCL material
Both tooth lines are made of DCL material. This material consists of a modified version of polymethyl methacrylate in which both the polymer and matrix are cross-linked. The result is a material that displays a higher compressive strength but a similar flexibility to conventional PMMA. The lifespan is therefore expected to be longer.

Delivery forms
SR Vivodent S PE anterior teeth are available in 15 maxillary and 5 mandibular moulds. The SR Orthotyp S PE posterior teeth are supplied in 4 maxillary and 4 mandibular sets. Both lines are available in 20 PE shades.
Ceramill® Liquid FX for accurate results

By Amann Girrbach

Easy, reproducible, precise – exact colouring of restorations in the 16 VITA classical tooth shades can be produced with the new, application-optimised Ceramill Liquids FX colour solutions, specially developed for the super-high translucent Ceramill Zolid FX Classic zirconia.

Top-level restorations can be fabricated with little customisation when used together with Ceramill Stain & Glaze for final customisation. This is possible thanks to compact, perfectly coordinated interplay between restoration material and colouring concept.

The milled restorations are customised with Ceramill Liquid FX in the pre-sintered state using the immersion or brush technique, so that the basic shade of the restoration is polychromatically shaded. This “foundation” forms the aesthetic basis for further processing using Ceramill Stain & Glaze and/or commercially available zirconia veneering porcelain.

Ceramill Zolid FX Classic, which can be used for monolithic and anatomically reduced anterior restorations as well as 5-unit bridges as far as the molar region, allows the fabrication of restorations that impress with their outstanding light transmission and brilliance. In addition, Ceramill Zolid FX does not age, ensuring long-term strength and stability of the restoration.

Ceramill Liquids are available in 16 VITA classical shades as well as shade modifiers for incisal/occlusal surfaces and the gingival region and do not have to be mixed, which promotes shade stability and saves time.

References
https://www.amann girrbach.com/company/news/?no_cache=1

Ceramill Liquid FX staining solution has been specially developed for Ceramill Zolid FX and guarantee an exact colouring at the first go.
Completely revised inLab software gives unprecedented freedom

By Sirona

Digital technology alone has no special value for a dental technician – it all depends on how the technology supports and improves the technician’s work without placing limits on it. The quantum leap in the designation of the new inLab software version from 4.2 to 15.0 demonstrates the new benchmarks: This software has a modular structure, is open, needs no dongle, covers new indications, and combines all steps in the production of restorations.

Bensheim/Salzburg, 25.06.2015. The inLab world of Sirona gives dental technicians complete freedom with regard to the choice of materials, indications and components. The inLab system is open.

The software is the core of the system and can be used as a separate component for all steps of work in the laboratory – CAI (computer aided impression) for the inEos scanner, CAM (computer aided manufacturing) to control the inLab MC XL and inLab MC X5 milling and grinding machines, and CAD (computer aided design) as design software for dental technology. In addition to the basic module that covers the main indications of the dental technology routine, various optional modules can be purchased. Sirona is starting with “Implantology” and “Removable prostheses” modules. The modular system makes the software transparent and comparable. Neither an annual license nor a dongle need to be purchased. Updating is also not required.

Optimal initial proposals thanks to biogeneric reconstruction

The completely redesigned CAD software has many new functions. For example, it is possible to design directly screw-retained bridges and bars and surgical guides for implantology. Also model cast STL designs for export can be made for further production. In addition to the integration of dental databases, the first jaw-oriented biogeneric reconstruction is an especially interesting feature. This application uses the intact remaining dentition of the entire jaw as a reference for an initial proposal that detects and utilizes not only the occlusal surfaces of the “real patient” but his individual jaw with respect to occlusion curves as well.

Sirona has also opened up the inLab product world of hardware – the inLab MC X5 is a laboratory unit designed for processing zirconium oxide, plastics, composites, wax, glass ceramic, hybrid ceramics, and metals in the form of blocks or disks. The machine allows the dental laboratory a free choice of all material suppliers that offer standard disks and it benefits additionally from the material competence of Sirona and its material partners VITA Zahnfabrik, Ivoclar Vivadent, DeutoKer, GC, 3M ESPE, and MEER.

“Dental technicians have full freedom,” explains Reinhard Pieper, head of inLab product management at Sirona. “They can use the new software to process all the data provided, whatever scanner they use or whatever intraoral camera their clients use to take an impression. It’s a flexibility which dental laboratories will benefit from in both the short and the long term.”

Fig. 1: With jaw-based biogeneric tooth alignment, the entire scanned jaw is included in calculating the proposal. Thus, not only chewing surface features but also shape and alignment of the teeth are considered.

Fig. 2: Dental technicians need freedom when planning the CAD/CAM infrastructure of their lab. Sirona hardware and software are open and thus comply with a basic demand of dental technicians.

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