For the 19th consecutive time, the UAE International Dental Conference and Arab Dental Exhibition (AEEDC) in Dubai will open its doors this week to visitors from the Middle East and beyond. The event is again being held under the patronage of His Highness Sheikh Hamdan bin Rashid al-Maktoum, Deputy Ruler of Dubai, Minister of Finance and President of the Dubai Health Authority, in co-operation with the Dubai Health Authority and will take place at the Dubai International Convention and Exhibition Centre from Tuesday to Thursday.

More than 30,000 dental professionals are expected to attend the event, which will present the latest concepts and innovations in dentistry and oral health prevention.

The scientific programme will be more extensive and more diverse than ever. According to Conference Chairman Dr Nasser al-Malki, visitors will have the opportunity to attend a record number of 116 lectures, specialty courses and workshops this year. More than 90 experts from the region and abroad will be presenting papers at the conference, which is being held in conjunction with a number of other events, including the International Symposium on Olympic and Sports Dentistry.

For the first time, AEEDC is collaborating with the Arabian Academy of Esthetic Dentistry to host the organisation’s third annual meeting in Dubai. This will see a series of specialised courses by some of the leading experts in aesthetic dentistry from around the world.

In response to the increasing number of French-speaking visitors from North Africa and Europe, French sessions have been added to this year’s offering as well. During the Stomatologie aujourd’hui sessions, French speakers will present their latest research and clini-
Minimum Intervention Dentistry (MID) is thought by many to be the new standard of dental care. When practicing this type of dentistry, common restoration techniques and materials have to be reconsidered. MID concepts are based on early diagnosis, disease risk assessment, prevention, and minimally invasive, non-traumatic procedures. For example, the pathogenic biofilm must be reduced to favour a healthy ecosystem and initiate healing. In this context, Ozone (O₃) has been proven useful.

The benefits of ozone therapy in MID will be demonstrated by Dr Fadi Sabbah, founding member of the International Association of Ozone in Healthcare and Dentistry and consultant for the International Scientific Committee on Ozone Therapy, at the booth of Hoffman Dental.

Dr Jean-Pierre Eudier, a French health advisor to governmental and non-governmental organisations and Visiting Professor at the Health Sciences University of Ulaan Bataar’s School of Dentistry in Mongolia, will also discuss the benefits of modified ART procedures using Copperion cement. The therapeutic filling material, sealing and/or bonding to affected decalcified structures, is non-toxic and has a strong antimicrobial effect that is crucial to the internal remineralisation of affected tooth structures.

Meet MID experts at Booth 7F10

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Organisers expect another record outcome in business transactions. According to al-Madani, exhibitors generated sales of more than US$2.4 billion after last year’s show.

For more information about AEEDC Dubai 2015, please visit the official website at aeedc.com.

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In addition to the scientific programme, visitors are invited to try out the latest innovations and services in dentistry at the global dental exhibition, al-Madani said. There, more than 1,400 manufacturers and distributors will be presenting their latest innovations, including new materials, as well as surgical and high-end dental equipment, such as CBCT imaging devices and sophisticated digital practice solutions. Among them will be a number of world premieres, such as Acteon’s new phosphor plate scanner and a topical fluoride varnish with calcium and phosphate for treatment of hypersensitivity from the GC Corporation.

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Electronic learning could enable millions more students to train as doctors and nurses worldwide, according to the latest research. A review commissioned by the World Health Organization (WHO) and carried out by Imperial College London researchers concluded that e-learning is likely to be as effective as traditional methods for training health professionals. These new findings support the approach to continuing education Dental Tribune International (DTI) has adopted with its free online education platform for dental professionals.

The Imperial team, led by Dr Josip Car, carried out a systematic review of the scientific literature to evaluate the effectiveness of e-learning for undergraduate health professional education. They conducted separate analyses on online learning, which requires an Internet connection, and offline learning, delivered via CD-ROMs or USB flash drives, for example.

The findings, drawn from a total of 108 studies, showed that students acquire knowledge and skills through online and offline e-learning as well as or better than they do through traditional teaching.

E-learning, the use of electronic media and devices in education, is already used by some universities to support traditional campus-based teaching or to enable distance learning. Wider use of e-learning might help to address the need to train more health workers across the globe. According to a recent WHO report, the world is short of 7.2 million health care professionals, and the figure is growing.

The authors suggest that combining e-learning with traditional teaching might be suitable for health care training, as practical skills must also be acquired. According to Car, from the School of Public Health at Imperial, “E-learning programmes could potentially help address the shortage of healthcare workers by enabling greater access to education; especially in the developing world the need for more health professionals is greatest.”

While the study focused on the education of students, DTI follows a similar approach to continuing education, offering webinars via its Dental Tribune Study Club, which it launched in 2009. The platform regularly offers free online courses and in several languages. The wide range of topics includes general dentistry, digital dentistry, practice management, as well as specialties, such as implantology and endodontology. The webinars are presented by experienced speakers and participants are awarded continuing education credits.
In a report, researchers of the Global Burden of Diseases, Injuries, and Risk Factors Study have recently shed light on the global dimensions of severe periodontitis, which now affects over 700 million people worldwide. This study is a major effort involving more than 1,000 scientists to systematically produce comparable estimates of the burden of 291 diseases and injuries and their associated 1,160 sequelae in 1990, 1995, 2005 and 2010. Dental Tribune UK had the opportunity to speak with lead author Prof. Wagner Marcenes from Barts and The London School of Medicine and Dentistry in London about the findings and why they are a cause for concern.

Dental Tribune: Prof. Marcenes, the prevalence of severe periodontitis on a global scale has not increased significantly in the last two decades, according to your report. Why are the numbers worrying nevertheless?

Prof. Wagner Marcenes: Having more than 700 million people suffering from severe periodontitis is really worrying. Although the proportion remained the same in 1990 and 2010, the number of people needing periodontal treatment has increased dramatically. This is because worldwide more than one in ten people suffer from severe periodontitis and the world population grew from 5.3 billion in 1990 to 6.9 billion in 2010. Moreover, severe periodontitis tends to develop during adulthood, showing a steep increase between the third and fourth decades of life. With more people living longer and retaining their teeth for life, the risk of developing severe oral health related problems, particularly periodontitis, will be high. The world’s population is expected to almost double by end of this century, implying that the number of people with severe periodontitis may at least double.

How do the results compare to the situation prior to the surveyed period?

We have updated the data from the first Global Burden of Disease (GBD) study and generated comparable figures in 1990 and 2010. Therefore, we were able to compare the current and the previous situation to our survey in 2010. Since the study is unique, we do not have global data before the first GBD study. However, we know that oral diseases have decreased significantly in most industrialised countries, such as the UK and the US, in the last five decades.

Severe periodontitis appears to be most prevalent in South America and east sub-Saharan Africa. What could be the reasons for that?

Our study was not actually designed to test risk factors of periodontal disease, but based on pure reasoning, I would say that, in addition to demographic changes, smoking and poor oral hygiene may be the main factors associated with it. This is speculation, but what we see at the moment is a growing number of people smoking in developing regions contrary to the trend in most developed countries. Nearly 80 per cent of the more than one billion smokers worldwide live in low- and middle-income countries. With 1,500 new cases every year, Argentina for example has the highest incidence of severe periodontitis, which is almost double the global average, and high tobacco consumption. We cannot establish a cause and effect relationship, but I believe that the high incidence of periodontitis in these areas is most likely related to the habit of smoking.

Is your representation of the situation therefore a realistic one?

I am confident our report provides a realistic, comprehensive assessment of the global burden of severe periodontitis. After much consideration, we used a Community Periodontal Index of Treatment Needs score of 4, a clinical attachment loss of greater than 6 millimetres or a pocket depth of more than 5 millimetres as indicators of periodontitis. We used the measurements adopted by the World Health Organization, which are considered by most as the most
reliable indicators of severe periodontitis. We endeavoured to reflect the measures adopted by the larger community of public health dentistry.

The choice of including only severe periodontitis and not less severe forms of periodontal disease, such as mild or moderate periodontitis and gingivitis, was because of their low impact (disability weight) on quality of life. Since periodontitis tends to progress from mild to severe if untreated, our numbers reflect only the tip of the iceberg, indicating the seriousness of the challenge to health professionals.

Why is the situation so little addressed by the dental community, and how could it be better addressed?

The fact that a preventable oral disease is the sixth most prevalent of all 291 diseases and injuries examined in the 2010 GBD is quite disturbing and should cause all of us to redouble our efforts to raise awareness of the importance of oral health among policymakers. It is reasonable to prioritise life-threatening diseases that have a greater impact on quality of life; however, it is unacceptable to neglect severe oral diseases. Untreated caries in the permanent dentition is the most prevalent of all oral diseases and periodontitis the sixth most prevalent disease in the world.

It is possible that the prevention and treatment of periodontitis are neglected because most health strategies target children at school and severe periodontitis is uncommon before the age of 20. I believe we need to seriously consider a change in strategy and target the adult population. Also, we should focus on determinants of health rather than the disease itself.

We call this the common risk factor approach. For example, many dental practices in the UK run smoking cessation programmes. This will not only reduce the number of cases of periodontitis but also help prevent life-threatening diseases, such as cancer and cardiovascular disease. Adopting the common risk factor approach would lead to the inclusion of oral health in the top five most relevant diseases. This is because oral diseases and serious life-threatening diseases share the same determinants, for example smoking, hygiene and diet.

Thank you very much for the interview. «

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While accountability and improvement have been eminent in health care systems for quite some time, there is probably no other time in history when the relevance and importance of these have been more advocated. Learning from our shortcomings and improving our health care system towards better patient care is the goal of clinical governance. I refer to it as the democracy of the health care system, in which all members of the health care team have the right to bring about positive changes.

Accountability and learning from self-criticism forms the basis of clinical governance, which provides the framework for taking all the steps necessary to make the system more patient friendly. It is a cyclical process that once established can help to identify the decisive factors for the quality of patient care. When asked by one of my trainees when the mechanisms of clinical governance ensure in everyday practice, my answer was, “In a patient-centred practice it never stops.” It starts as early as the patient first contacts a practice or a hospital and encompasses the entire health care scenario, starting with welcoming and managing a new patient, ensuring his or her safety on our premises and advising him or her about all aspects of treatment. This combination is all about our transparency to the outside world, ensuring that arbiters and our patients can be certain of our quality of care.

More simply put, clinical governance is the umbrella under which we can provide the best care possible for our patients. It is a structural framework that incorporates all pillars of the health care system. There are channels for the health care team, management and patients alike. Particularly for the last, clinical governance provides an environment free from potential hazards. In addition, patients are given a voice in the system through patient feedback, ensuring that if they draw attention to any wrongdoing, lessons are learnt and such mistakes are not repeated.

For our staff and team members, clinical governance ensures that they will be inducted into the system effectively in the beginning and be a part of that system through organisational meetings and their annual appraisals throughout their whole career. This way, they will have the best opportunity to improve their skills and advance their professional development. Moreover, this allows them to better judge their clinical effectiveness and communication skills.

Since training and career development are integral parts of clinical governance, it helps the clinicians to identify their learning needs and plan their continued professional development accordingly. Continuing in this loop, they are able to develop improved awareness about the safety of their work environment, risk management is one of the basic pillars of clinical governance. Through research and development opportunities, they can also learn new skills and treatment protocols.

Clinical governance is the girdle of an organisation in a health care system: it encompasses all aspects of improved patient care and keeps all involved units in the loop. The management of an organisation can monitor the quality of care provided by it. It can also rate the clinical effectiveness of a particular specialty or clinician. With patient feedback, it can furthermore identify any shortcomings in the system. It will compel the organisation to strive for the professional development of its employees, safeguarding the clinician’s right to develop professionally. The impartiality of the system opens the organisation to scrutiny and maintains the absolute system of checks and balances.

Audit is an indispensable part of clinical governance, as it allows the system to self-analyse and induce changes, if needed, that is, we make improvements and then reaudit. Once this cycle has been initiated, it will become a continuous process of reanalysis and improvement. The prime feature of this system is that the whole process is self-sustainable once the system has been implemented. The checks and balances in the system will keep it going and evolving.

The process of clinical governance is quite well established in the Western world, but it is time that this essential system of health care delivery become established in developing economies. After all, it is all about the patients: it is to ensure their continued good care that we study intensely and pursue professional development.

Dr Kashif Hafeez will provide controversial insights into the issues of clinical governance during a presentation on Thursday morning as part of the scientific programme of AEDC Dubai 2015. He is currently in private practice in Carterton in the UK.
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Infection control in an era of emerging infectious diseases

By AEEDC Dubai 2015 presenter Eve Cuny, USA

More than three decades have passed since the emergence of human immunodeficiency virus (HIV) as a global pandemic. More than any other infection, it is possible to single out HIV as the primary stimulus for changing infection control practices in dentistry. Prior to the mid-1980s, it was uncommon for dentists and allied professionals to wear gloves during routine dental procedures. Many dental clinics did not use heat sterilisation, and disinfection of surfaces was limited to a cursory wipe with an alcohol-soaked gauze sponge. This was despite our knowledge that hepatitis B virus (HBV) had been spread in clusters in dentists and that dentists were clearly at occupational risk for acquiring HBV.

Today, many take safe dental care for granted, but there is still reason to remain vigilant in ensuring an infection-free environment for providers and patients. HIV has fortunately proven to be easily controlled in a clinical environment using the same precautions as those effective for preventing the transmission of HBV and hepatitis C virus. These standard precautions include the use of personal protective attire, such as gloves, surgical masks, gowns and protective eyewear, in combination with surface cleaning and disinfection, instrument sterilisation, hand hygiene, immunisation and other basic infection control precautions. Sporadic reports of transmission of blood-borne diseases associated with dental care continue, but are most often linked to breaches in the practice of standard precautions.

Emerging and re-emerging infectious diseases present a real challenge to all health care providers. Three of the more than 50 emerging and re-emerging infectious diseases identified by the Centers for Disease Control and Prevention and the World Health Organization (WHO) include Ebola virus disease (EVD), pandemic influenza and severe acute respiratory syndrome.

These previously rare or unidentifiable infectious diseases burst into the headlines in the past several years when they exhibited novel or uncharacteristic transmission patterns.

Concern about emerging infectious diseases arises for several reasons. When faced with a particularly deadly infectious disease such as EVD, which can be spread through contact with an ill patient’s body fluids, health care workers are naturally concerned about how to protect themselves if an ill patient presents to the dental clinic. With diseases such as pandemic influenza and severe acute respiratory syndrome, which may be spread via inhalation of aerosolised respiratory fluids when a patient coughs or sneezes, the concern is whether standard precautions will be adequate.

In addition to standard precautions, treating patients with these diseases requires the use of transmission-based precautions. These encompass what are referred to as contact, droplet and airborne precautions for diseases with specific routes of transmission. Transmission-based precautions may include patient isolation, placing a surgical mask on the patient when he or she is around other people, additional protective attires for care providers, and in some cases the use of respirators and negative air pressure in a treatment room. In most cases, patients who are contagious for infections requiring droplet or airborne precautions should not be treated in a traditional dental clinic setting.

Updating a patient’s medical history at each visit will assist dental health professionals in identifying patients who are symptomatic for infectious diseases. Patients with respiratory symptoms, including productive cough and fever, should have their dental treatment delayed until they are no longer symptomatic. Additionally, health care professionals who are symptomatic should refrain from coming to work until they have been free of fever without taking fever-reducing medication for 24 hours.

In most cases, a patient with symptoms as severe as those experienced with EVD will not present for dental care and therefore extraordinary screening and protection protocols are not recommended. If a patient is suspected of having a highly contagious disease, he or she should be referred to a physician, hospital or public health clinic.

Dental professionals should take action to remain healthy by being vaccinated according to accepted public health guidelines, understanding that the recommendations may differ according to country of residence. Performing hand hygiene procedures at the beginning of the day, before placing and after removing gloves, changing gloves for each patient, wearing a clean mask and gown or laboratory coat, and wearing protective eyewear are all positive actions that help prevent occupational infections. In addition, cleaning and heat sterilisation of all instruments and disinfection of clinical surfaces ensure a safe environment for patients. There is solid evidence that dental care is safe for patients and providers when standard precautions are followed, but patients and dental health care workers are placed at risk when precautions are compromised and breaches occur.

Eve Cuny is an associate professor at the Arthur A. Dugoni School of Dentistry at the University of the Pacific in San Francisco in California in the US. She is also a consultant to the American Dental Association’s Council on Scientific Affairs and expert reviewer for the Centers for Disease Control and Prevention. At AEEDC Dubai 2015, she will be presenting two papers discussing infection control in dentistry on Tuesday and Thursday.

References:
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Photo-functionalisation is effective on any implant surface type

An interview with AEEDC Dubai presenter Dr Takahiro Ogawa, US

Dr Takahiro Ogawa

UAE International Dental Conference and Arab Dental Exhibition (AEEDC) in Dubai about the technique as part of the official congress programme. Today international had the opportunity to talk with him in advance about the benefits and prospects of this innovation.

today international: Photo-functionalisation is achieved by exposing titanium surfaces to ultraviolet light. Would you describe this in more detail and the mechanical or chemical processes that take place during the process?

Dr Takahiro Ogawa: Photo-functionalisation is a 12-minute conditioning of dental implants in the device immediately prior to implant placement. The reason for this process is that titanium ages with time, and this particularly affects its ability to integrate with bone.

The aging process of implants degrades hydrophilicity. Can the features of an aged implant surface be fully restored by photo-functionalisation, and does the technology have any limits?

All this is intended to make osseointegration of dental implants much better and faster. The photo-energy activation device boasts an optimised combination of ultraviolet lights that effectively remove hydrocarbon from the implant surface, transforming the surface from hydrophobic (water-repelling) to hydrophilic (water-friendly). This change in properties, together with the clean titanium surface, attracts more osteogenic cells. Photo-functionalised titanium surfaces are electrostatically positive and further enhance cell attraction because cells are electro-negative.

Not at all. A series of studies have indicated that photo-functionalisation is effective on any implant surface type tested whether acid-etched, dual acid-etched, oxidised, sand-blasted, nano-featured or machined surfaces.

As-received

Photo-functionalised

The photo-energy activation device boasts an optimised combination of ultraviolet lights that effectively remove hydrocarbon from the implant surface, transforming the surface from hydrophobic (water-repelling) to hydrophilic (water-friendly). This change in properties, together with the clean titanium surface, attracts more osteogenic cells. Photo-functionalised titanium surfaces are electrostatically positive and further enhance cell attraction because cells are electro-negative.

While photo-functionalisation can restore implant properties to a degree similar to when it was manufactured, the revitalised implant surfaces degrade time-dependently in the same way as those of regular implants. Therefore, dental implants undergoing treatment with the device need to be placed immediately.

Has the technique been tested in vivo studies and, if so, what results have you found so far?

According to a number of preclinical studies, the strength of osseointegration can be increased three times by photo-functionalisation at the early healing stage. The bone-implant contact of photo-functionalised implants reached 94.2%, compared with 59–55% achieved with the control implants.

Moreover, it has been found that photo-functionalisation increases the quality of marginal bone formation, as well as improves the outcome of guided bone regeneration, when applied to titanium mesh. Photo-functionalisation also makes implant and abutment surfaces bacteria-phobic.

The aging process of implants degrades hydrophilicity. Can the features of an aged implant surface be fully restored by photo-functionalisation, and does the technology have any limits?

Studies indicate that there are not only short-term benefits of photo-functionalisation. Reliability and predictability in function and aesthetics are expected to increase with time, providing clinicians with a new strategy for a better long-term prognosis for dental implants and reducing the risk of peri-implantitis.

You say that photo-functionalisation could become a standard procedure for dental implant therapy. When will that happen, in your opinion?

Dentists in Japan have been using photo-functionalisation for approximately three years. In Europe, pre-marketing of the device has recently started. I believe that other regions will catch up shortly and make this technology a global standard in implant dentistry.

A number of projects are also underway utilising photo-functionalisation in the field of general bone engineering and orthopaedic implants and reconstruction.

Thank you very much for the interview.
Conference programme of AEEDC Dubai 2015

Tuesday, 17 February

9:00 – 10:00 Direct posterior restorations: Guilt or durability, AEEDC Conference Hall – A
Speaker: Fedel Ali Alsababan

10:30 – 11:00 The oral pre-participation exam, AEEDC Conference Hall – E
Speaker: Anthony Clough

11:15 – 11:35 Dental injuries in sports: Ice hockey, AEEDC Conference Hall – E
Speaker: Jean Luc Dion

Speaker: Angelo Putignano

13:00 – 13:30 Treatment in the Deciduous and Mixed Dentition, AEEDC Conference Hall – D
Speaker: Colin Murray

16:30 – 17:00 Dilemma of nonvital teeth during endodontic treatment, AEEDC Conference Hall – C
Speaker: Mohamed Sultan Al Darwish

17:15 – 17:30 New perspectives in enhancing implant-tissue synergy, AEEDC Conference Hall – E
Speaker: Reema Abed Al Ghaithy

19:00 – 19:30 Anti-aging orthodontics, AEEDC Conference Hall – C
Speaker: Jean Luc Dion

19:45 – 20:15 Tooth surface loss – From diagnosis to management: A literature review, AEEDC Conference Hall – A
Speaker: Mohammed Amed El Romashko

20:30 – 21:00 Denture relining materials, AEEDC Conference Hall – B
Speaker: Ray Padilla

Wednesday, 18 February

9:00 – 09.30 GCC Preventive Dentistry Session: Caries prevention in infants, AEEDC Conference Hall – A
Speaker: Huda Nazar

09:00 – 09:45 Dental digital education: Four years’ experience in a Riyadh college, AEEDC Conference Hall – B
Speaker: Yusuf Al Shammery

10:00 – 10:30 Strategies for craniofacial re-generation, AEEDC Conference Hall – D
Speaker: Charles Steir

12:15 – 12:45 How to create predictable endodontic canal shapes in your practice, AEEDC Conference Hall – C
Speaker: Ray Padilla

16:30 – 17:00 Repair & regeneration in endodontics (Part 1), AEEDC Conference Hall – B
Speaker: Donald Ferguson

17:15 – 17:45 The use of botulinum toxin Type A in conjunction with and without occlusal splint therapy

About the Publisher

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as a symptomatic treatment of temporomandibular joint disorders, AEEDC Conference Hall – E
Speaker: Ahmed Abdelhamid
09:45 – 10:30
Regenerative dentistry: Combination of dental stem cell therapy and nanotechnology, AEEDC Conference Hall – F
Speaker: Thimios Mitsisidis
10:00 – 11:00
Bioenergetic Age: A new era?, AEEDC Conference Hall – A
Speaker: Guillaume Jouannay
Cranial facial growth and implant reconstruction in adults: Observations, consequences and surgical solutions, AEEDC Conference Hall – C
Speaker: Oded Bahat
10:30 – 11:00
Sinus avoidance: Keeping implant dentistry simple, AEEDC Conference Hall – D
Speaker: Crawford Bain
10:30 – 11:00
Current & future concepts in TMJ management, AEEDC Conference Hall – E
Speaker: Mohomed A. Al-Mubarakhi
10:30 – 11:15
The impact on dental education programmes, AEEDC Conference Hall – B
Speaker: David Wray
Direct pulp capping with tri-calcium silicates and pulp regeneration, AEEDC Conference Hall – E
Speaker: Iyad Hussein
11:15 – 12:00
A modern dental education model integrating public health into total health, AEEDC Conference Hall – B
Speaker: Jack Dillenberg
Stomatolodgy today, AEEDC Conference Hall – F
Speaker: Jean-Christophe Fricain
11:15 – 12:15
Less grafts, more implants & same-day teeth, AEEDC Conference Hall – A
Speaker: Costa Nicolaou
The role of adhesion in direct and indirect restorative dentistry, AEEDC Conference Hall – C
Speaker: Pedro de Vries
12:00 – 12:45
The use of social media in oral health promotion and education, AEEDC Conference Hall – E
Speaker: Tony Hashemian
Current approaches of oral cancer diagnosis, AEEDC Conference Hall – F
Speaker: Ahmed Feki
12:15 – 12:45
Pulp therapy in primary teeth: Treatment options, AEEDC Conference Hall – D
Speaker: Olivier Winand
Tackling the endo-perio conundrum, AEEDC Conference Hall – E
Speaker: Leena Beever
15:30 – 16:30
Treatment planning session
Speaker: Enrico Steger
15:30 – 17:30
A new era in paediatric dentistry, AEEDC Conference Hall – D
Speaker: Naol Quaktit & Ali Attiya
15:45 – 16:30
Apical surgery: Does it really work?, AEEDC Conference Hall – B
Speaker: Mohammad Alloplon Alazzam
16:00 – 16:30
3-D bone defect treatment in the aesthetic zone, AEEDC Conference Hall – E
Speaker: Ehab Rashid
16:00 – 16:45
The oral mucosa as a mirror of systemic diseases: How to avoid pitfalls in treatment of the elderly, AEEDC Conference Hall – A
Speaker: Jürgen Ervens
16:30 – 17:30
Aesthetic rehabilitation of malpositioned teeth with porcelain laminate veneers: A viable alternative to orthodontics, AEEDC Conference Hall – B
Speaker: Rusti Giannakopoulos
14:00 – 14:45
Bet’s it stick together: Modern cementation techniques for the clinician, AEEDC Conference Hall – A
Speaker: Michael Dieter
Soft tissue considerations around teeth and implants, AEEDC Conference Hall – E
Speaker: Korkut Demirli
14:00 – 15:00
Mastering endodontic rotary instrumentation and techniques to reach the highest level of success, AEEDC Conference Hall – B
Speaker: Roger Rebeiz
Assessment, diagnoses and re- ferral of orthodontic patients, AEEDC Conference Hall – D
Speaker: Mohamed Al-Mahbouby
14:30 – 15:30
Innovative CAD/CAM technologies, AEEDC Conference Hall – C
Speaker: Lawrence Freudenthal
14:45 – 15:30
Lasers in dentistry, AEEDC Conference Hall – A
14:45 – 15:30
Periodontal consideration in implant dentistry, AEEDC Conference Hall – E
Speaker: Mohammad Fokliest
15:00 – 16:30
Orthodontic management of im- pacted teeth, AEEDC Conference Hall – D
Speaker: Amir Nobil Asher
15:00 – 15:45
Root canal disinfection: What we know and what we need to know, AEEDC Conference Hall – B
Speaker: Prasanna Neelakantan
15:30 – 16:00
Low level laser therapy with a diode laser to support the wound healing after oral surgical interventions, AEEDC Conference Hall – A
Speaker: Olivier Winand
9:00 – 11:00
Thursday, 19 February
09:00 – 09:30
Accountability in dental prac- tice: Clinical governance, AEEDC Conference Hall – B
Speaker: Kashif Hafeez
Case presentation with interactive discussion, AEEDC Conference Hall – C
Speaker: Shahid Chandra Pani, Hizhekh Mosadoni, Abdullah Al Shammery-Saleh, Sharmarri
09:00 – 09:40
Apical surgery or endodontic treatment: Is the choice always changing from 2-D to 3-D?, AEEDC Conference Hall – A
Speaker: Housam Fouad
09:30 – 10:15
Fee setting, AEEDC Conference Hall – B
Speaker: Elhab Mokdad
09:40 – 10:20
Dental erosion and remineralization agents: Myths and realities, AEEDC Conference Hall – F
Speaker: Saoud Gholi
09:45 – 10:30
Lip repositioning: A newly dis- cussed treatment modality for gummy smile reduction, AEEDC Conference Hall – C
Speaker: Abdulmagid El-Kaissi
10:00 – 11:00
Beyond conventional alveolar bone grafting, AEEDC Conference Hall – D
Speaker: Sinarath Vakkhekhad Prasad
The role of endoscopy in dental implant therapy, AEEDC Conference Hall – E
Speaker: Saeed Al-Habsh
14:05 – 17:30
Future vision of clinical non-invasive modalities in diagnosis of oral squamous cell carcinoma (OSCC), AEEDC Conference Hall – A
Speaker: Eman Ahmed Omar
10:30 – 11:00
Management of trauma in adult patients
AEEDC Conference Hall – A
Speaker: Ahmed Haider
10:30 – 11:15
Therapeutic options, AEEDC Conference Hall – B
Speaker: Majid Al-Adnani
11:30 – 12:30
The effect of arginine in neutralizing biofilm acids, AEEDC Conference Hall – D
Speaker: Roy Abu Fadel
12:00 – 12:45
Ceramic veneers: Where are the limits? , AEEDC Conference Hall – A
Speaker: Dimitri Flitchett
12:00 – 16:00
Lip repositioning: A newly dis- cussed treatment modality for gummy smile reduction, AEEDC Conference Hall – C
Speaker: Abdelmagid El-Kaissi
Digital smile design: Why changing from 2-D to 3-D?, AEEDC Conference Hall – D
Speaker: Alain Mecht
Delivering clinical perfection: Direct composite restorations, AEEDC Conference Hall – E
Speaker: Nassib Fares
12:20 – 13:00
Per and pre-implant oral tissue regenerative procedures in the ante- rior maxilla, AEEDC Conference Hall – F
Speaker: Baccouche Mohamed Chedly
14:00 – 14:30
Antibiotic abuse, AEEDC Conference Hall – A
Speaker: Ahmed Halim Ayoub
09:00 – 10:00
Effect of Mandibular Repositioning Appliances on Inspiratory and Expiratory Total Air, AEEDC Conference Hall – D
Speaker: Adil Osman Mageet
11:15 – 12:00
Periodontal disease and diabetes: A two-way relationship, AEEDC Conference Hall – C
Speaker: Crawford Bain
11:15 – 12:00
Socket preservation in implant dentistry, AEEDC Conference Hall – F
Speaker: Michael A. Apa
Spray painting the success of, AEEDC Conference Hall – A
Speaker: Housam Fouad
11:40 – 12:20
Direct aesthetic provisional ap- plication: Enabling the artist inside, AEEDC Conference Hall – E
Speaker: Roy Abu Fadel
14:00 – 14:45
Application of fibre reinforced reconstructions: From splints to direct adhesive bridges, AEEDC Conference Hall – A
Speaker: Mariel Garza
14:00 – 14:45
Exposure therapy for the treat- ment of an adult needle phobic, AEEDC Conference Hall – D
Speaker: Iyad Ilyas
Advanced digital implant con- cepts: As simple as possible, as effective as necessary, AEEDC Conference Hall – E
Speaker: Marcus Abboud
Aesthetic can range from changing life style to changing the future of a patient, AEEDC Conference Hall – F
Speaker: Abdullah A Faidhi
14:00 – 14:45
The influence of serotonin on enamel formation and maturation: Comparative studies between the molars and incisors, AEEDC Conference Hall – C
Speaker: Michel Goldberg
14:30 – 15:15
Burning mouth syndrome: Is she crazy?, AEEDC Conference Hall – B
Speaker: Nadim Islam
14:45 – 15:30
Optimising dental aesthetics with ceramic laminate veneers, AEEDC Conference Hall – A
Speaker: Tariq F. Alghazzawi
14:45 – 15:30
New possibilities of bone engineering, AEEDC Conference Hall – E
Speaker: Emad Salloum
14:45 – 15:45
Conscious sedation in the dental office, AEEDC Conference Hall – D
Speaker: Nabeel Assudmi
Digital implants registration vs. conventional implants impression, AEEDC Conference Hall – F
Speaker: Emilio Rodriguez Fernandez
15:00 – 15:45
Oral health status and behaviours of children with autism spectrum disorders, AEEDC Conference Hall – C
Speaker: Amira A.Habez El Khatib
15:15 – 16:00
How well do dentists recognise orofacial pain in the clinic?, AEEDC Conference Hall – B
Speaker: Saud Orfali
15:30 – 16:15
Good communication between dentist and dental technician: Key to success, AEEDC Conference Hall – A
Speaker: Lamberto Villani, Ajay Juneja
15:45 – 16:30
Dental treatment under general anaesthesia, AEEDC Conference Hall – C
Speaker: Suha Al Farhan
15:45 – 16:45
Characteristics of root canal instruments and its clinical implication, AEEDC Conference Hall – D
Speaker: Kimhyeon Cheol
Exposure incident prevention and response disinfection and sterilization protecting yourself and your patients from infectious diseases, AEEDC Conference Hall – F
Speaker: Eve Cuny
Is dentistry ready for a new standard of care?

Dr Lee M. Whitesides, USA

Since its commercial introduction into dentistry in 2001, cone beam computed tomography (CBCT) has been rapidly evolving into a new standard of care in maxillofacial imaging. In just over a decade, CBCT has exploded onto the dental landscape and permitted dental professionals a degree of three-dimensional (3-D) anatomic truth in maxillofacial imaging previously unavailable and unattainable. Like many other new technologies, which have progressed from the extraordinary to the ordinary and thus gained acceptance by professionals, CBCT has advanced from exceptional use to almost common-place use in dentistry as cost decreases, access to the technology increases, and potential adverse patient interaction (i.e. radiation exposure) is attenuated. Today, CBCT is seen by many in dentistry as the standard operating procedure for many dental implant, orthognathic, orthodontic, or endodontic cases.

The advancement of CBCT in dentistry has caught the attention of manufacturers of radiological equipment. In 2001, only one company sold a CBCT system. In 2014 there are at least 20 companies selling CBCT machines and technology. Henry Schein, a leading distributor of dental equipment, has seen CBCT sales expand from 5% of their digital imaging sales to almost 20% of their digital imaging sales in the last five years.

CBCT has also been recognized by general dentists and specialists as a means by which they can separate their talents and distinguish their practices as being on the vanguard of technology in patient care. Today’s patients expect their dentists to be conscientious adopters and disseminators of emerging technology, which not only advances patient care improve. An appropriate adoption of CBCT by the dental professional is rapid, and benefits of the technology are immediately realized.

However, CBCT is not just 3D imaging. CBCT is a comprehensive imaging system. The machine can be utilized for a fee, thereby reducing his overall cost of care. Patients present to their dentist with symptoms that may include such language as: the dentists is under duty to use that degree of skill and care which is expected of a reasonably competent and prudent dentist under the same or similar circumstances. Standards of care may be local, regional or national.

Standard of care influences

The influence of an emerging technology, like CBCT, into a new standard of care involves many criteria. These criteria include but are not limited to: court verdicts, expert testimony, literature support, professional guidelines, cost and availability of the technology, reimbursement by third party payers, and multi-specialty use and recognition.

Taken individually, these criteria do not constitute a mandate for any technology as a standard of care. Nor are these the only criteria one may use in determining standard of care. Taken together, these criteria provide strong evidence that CBCT technology has sufficiently evolved to be considered the standard of care in maxillofacial imaging in selected cases to assist the dentist in treatment for patients in need of dental implants, orthognathic surgery, manipulation of difficult impacted teeth, orthodontics, endodontics, and many other facets of dentistry.

The legal perspective

The legal system in the United States is complex and fragmented. No database exists to search verdicts in dental malpractice cases in which CBCT has played an important or pivotal role. For a new technology to become admissible as a standard of care in court, it must pass the Frey test. This standard comes from Frey v. United States which was a 1923 case discussing the admissibility of a polygraph test as evidence. The Frey standard maintains that scientific evidence presented to the court must be interpreted by the court as “generally accepted” and expert testimony must be based on scientific methods that are sufficiently established and accepted.

In Frey, the court opined: “Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognised, and while the courts will go a long way in admitting experimental testimony derived from a well recognised scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.”

In many jurisdictions and in Federal court, the Frey standard is superseded by the Daubert standard. The Daubert standard is used by a trial judge to make a preliminary assessment of whether an expert’s scientific testimony is based on reasoning or methodology that is scientifically valid and can properly be applied to the facts at issue. Under this standard, the factors that may be considered in determining whether the methodology is valid are:

- theory or technique in question can be and has been tested,
- it has been subjected to peer review and publication,
- there is a known or potential error rate,
- the existence of maintenance standards controlling its operation,
- widespread acceptance within a relevant scientific community.

The theory or technique behind medical grade computed tomography and CBCT have been tested and proven sound over many years of application in the medical and dental arena. The Hounsfield unit is the widely recognized standard quantitative scale for describing radiodensity and provides doctors with a known standard and error rate in computed tomography. The widespread acceptance of CBCT by the medical and dental community is demonstrated by the ever increasing presence in dental and medical practices of the technology. Additionally, The Intersocietal Accreditation Commission, an accreditation organisation for medical and dental imaging, has developed guidelines and accreditation criteria for 3-D CBCT imaging. Thus CBCT appears to have satisfied both the Frey and Daubert criteria for acceptability as a standard of care technology.

Not to discount the value of CBCT imaging or its ability to successfully satisfy the Frey or Daubert criteria, the absence of CBCT is not de facto evidence of lack of a standard of care. Many patients present to their dentist with uncomplicated cases where traditional two-dimensional radiographic studies are appropriate and provide the dentist with standard of care imaging of the patient. For the more complicated cases, 3D imaging may be employed to provide the dentist with superior anatomic evidence in treatment planning and diagnosis. Three-dimensional imaging with CBCT can also be used in uncomplicated cases, but it may not necessarily be considered as the standard of care for every case in 2014.

Expert Testimony

An expert is a person with sufficient minimal qualifications to render an opinion on the subject at hand. Not all experts are created equal, and in fact in three states (Iowa, South Dakota, and New Hampshire) an expert need only be qualified in a related field to offer an opinion. Experts are used by the courts to educate the judge and jury as to what constitutes normal malpractice, the standard of care in a given environment.

Expert testimony is by definition the opinion of one practitioner. It is an opinion based on fact, evidence, experience, and knowledge which the expert believes to be relevant, valid, and upheld in the scientific community.

When reviewing a case for suspected malpractice the expert examines many things, including, but not limited to: chart notes, radiographic studies, depositions, and professional correspondences. In the last five years, the author has noticed a remarkable increase in the number of cases in which plaintiffs and defense attorneys, as well as experts, rely on pre and post-procedure CBCT imaging studies to assist in proving malpractice or defending good practice. Post-treatment radiographic imaging to demonstrate that “good practice” is not new to medicine. In fact in the years preceding WWI, some of the highest malpractice claims were awarded in cases where post-treatment radiographs played a pivotal role.

Logic would dictate that ifplain-tiffs and defense councils and experts are making CBCT part of their strategy, then CBCT must be not only prevalent and pertinent but of significant value in the formation of an opinion by an expert (and also the jury) when reviewing a case. CBCT imaging can be seen as an additional and important piece of information to help explain why the dentist did what he did and give context to an unfortunate outcome occurred. Additionally, CBCT provides powerful and easily understandable images for layperson jury.

Recognizing the value that CBCT adds to a case does not necessarily indicate that CBCT is the standard of care in every case. The decision to obtain a CBCT study before the procedure is determined by the dentist based on his experience and knowledge of the case.

Literature Support

For any technology to be considered as a standard of care, a plethora of literature in support for the technology should exist. The literature must discuss the risk and benefits of the technology, its application to patient care, and guidelines and protocols for acceptable use.

To assess the influence of CBCT in the dental literature, the author performed a PubMed literature search in October for the words
cone beam CT, cone beam CT + dental, cone beam CT + orthodontics, cone beam CT + oral surgery, cone beam CT + endodontics in the search line. The results are in Table 1.

Evaluation of Table 1 clearly shows a significant presence in the literature of articles pertaining to the use of CBCT in the various disciplines in dentistry. The vast majority of literature discovered pertains to addressing the use of CBCT in treatment planning and diagnosis of patients in dental implant therapy, oral and maxillofacial surgery, orthodontics, and endodontics. Articles on new applications of CBCT technology to patient care were also prevalent in the sample. Some articles addressed the risk and benefits of CBCT but none denounced CBCT as harmful to the patient or insignificant in treatment planning and diagnosis. Two similar PubMed reviews of the literature on CBCT were performed by authors Alamri et al (Applications of CBCT in dental practice: A review of the literature. Gen Dent 2012; 60(5): 390–400) and De Vos et al (Cone-beam computed tomography (CBCT) imaging of the oral and maxillofacial region: A systematic review of the literature. Int J Oral Maxillofac Surg 2009; 38: 609–625). Both of these exhaustive articles demonstrate the plethora of literature addressing CBCT and its application in the many disciplines in dentistry.

**Professional Guidelines**

For a technology such as CBCT to become a standard of care in dentistry, guidelines for its use and application in patient care must be established by the organisational bodies of those disciplines in dentistry who employ the technology to treat patients. In dentistry, the dental practitioners most involved in the use and application of CBCT in patient care include general dentists, oral and maxillofacial surgeons, endodontists, oral and maxillofacial radiologists, orthodontists, and periodontists.

The American Dental Association has over 180,000 licensed dentists representing approximately 75% of dentists in the USA. The American Dental Association published an advisory statement article in its principal journal, The Journal of the American Dental Association, in August 2012. The article discusses the many positive aspects of CBCT, but stops short of calling CBCT a new standard of care. Rather, the ADA encourages the dentist to use CBCT “selectively, as an adjunct to conventional radiography.” The ADA further recognises the value and presence of CBCT by including CBCT-related courses at its annual meetings and continuing education courses during the year.

The American Association of Oral and Maxillofacial Radiology (AAOMR) has worked with the IAC to develop guidelines and accreditation criteria for 3D CBCT imaging. In recent survey of OMFS residency programmes, 87% of programme directors acknowledged the use of CBCT in patient care by their residents.

The American Association of Endodontists (AAE) and the American Association of Oral and Maxillofacial Radiologists (AAOMR) have released a formal position paper on CBCT. This paper makes many important points, such as limiting the field of vision to minimise radiation exposure and increase resolution, careful patient selection in CBCT, and the responsibility of the clinician to interpret the entire image. The position paper goes on to declare “the use of CBCT in endodontics should be limited to the assessment and treatment of complex conditions.”

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**Key words in search**

<table>
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<tr>
<th>Key words in search</th>
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<th>Year article first appeared</th>
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<td>CBCT + endodontics</td>
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**Table 1**
Literature pertaining to the use of CBCT in endodontics first appeared in the *Journal of Endodontics* in 2000. The American Association of Endodontists (AAE) and the American Dental Association (ADA) have produced position papers on CBCT technology. The AAE argues that CBCT is a valuable tool for the diagnosis and treatment planning of dental endodontic cases. The ADA’s position paper states that CBCT is a valuable tool for the diagnosis and treatment planning of dental endodontic cases. The use of CBCT in endodontics is supported by numerous studies and has been shown to improve the accuracy of endodontic treatment planning and diagnosis.

In orthodontics, CBCT has become an important tool for assessing the position of teeth and bone structures. The use of CBCT in orthodontics has been adopted by many orthodontists, and it is becoming increasingly common in orthodontic practice. The American Association of Orthodontists (AAO) has produced position papers on CBCT technology. The AAO’s position paper states that CBCT is a valuable tool for the diagnosis and treatment planning of dental endodontic cases. The use of CBCT in endodontics is supported by numerous studies and has been shown to improve the accuracy of endodontic treatment planning and diagnosis.

In implant dentistry, CBCT has been shown to be a valuable tool for assessing the position of implants and bone structures. The use of CBCT in implant dentistry has been widely adopted by many implant dentists, and it is becoming increasingly common in implant dentistry practice. The American Association of Oral and Maxillofacial Surgeons (AAOMS) has produced position papers on CBCT technology. The AAOMS’s position paper states that CBCT is a valuable tool for the diagnosis and treatment planning of dental endodontic cases. The use of CBCT in endodontics is supported by numerous studies and has been shown to improve the accuracy of endodontic treatment planning and diagnosis.

In conclusion, CBCT technology is a valuable tool for the diagnosis and treatment planning of dental endodontic cases. The use of CBCT in endodontics is supported by numerous studies and has been shown to improve the accuracy of endodontic treatment planning and diagnosis.
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“The Middle East is no different than other parts of the world”
An interview with Danaher executives James Lico and Alex Joseph

Danaher is a global science and technology innovator committed to helping its customers solve complex challenges and improving quality of life around the world. Its family of world-class brands have unparalleled leadership positions in some of the most demanding and attractive markets, including health care, environmental and industrial. At the recent opening of Danaher’s MEA office in Dubai Healthcare City, Dental Tribune Middle East & Africa had the opportunity to speak with James Lico, Executive Vice President, and Alex Joseph, President Middle East and Turkey, about their thoughts on the region.

Dental Tribune MEA: What does the opening of the MEA office in Dubai Healthcare City mean for DANAHER?
Alex Joseph: The opening highlights our commitment to the Middle East region. It is also a direct result of the growth we have been experiencing in the region.

What benefits does it have for you to have one office in Middle East and North Africa?
James Lico: As Alex mentioned, the region is incredibly important for us. Unlike many companies who focus on just selling here, we consider it rather important to be close to customers and build up the capabilities of our team locally. The opening of this office really proves we not only want to do business in the region but also invest in the long run to serve our customers.

How much does your dental portfolio contribute to your overall business?
Alex Joseph: The dental business has been a major contributor to our growth in the region. Right now, there is an increased focus on dental care in the Middle East. Through our broad dental product portfolio ranging from dental instruments to treatment centres, imaging equipment, orthodontic technology and dental consumables as well as leading brands such as KaVo, Kerr, Gendex, Pelton & Crane, Ormco, Instrumentarium, Soredex, iCat and Dexis, to name a few, just Danaher serves customers across all segments. We believe that we provide our customers the highest quality dental products and solutions that serve 99 per cent of dental practices throughout the world.

Can we expect to see more dental companies joining Danaher anytime soon?
James Lico: As you might already know, we recently announced our latest addition with the acquisition of Nobel Biocare which was closed beginning of December 2014. We actually never comment on acquisitions but I think that the dental market is a growing platform within the Danaher group. In terms of investing in high growth markets, the Middle East is no different than other parts of the world and our dental team here has really done an outstanding job over a number of years investing in products, technology, sales and services resources to make sure that we can really deal with the growing customer base that exists in the region.

Obviously, this is a Danaher investment but it can very much be seen as an investment in our growing platforms, of which the dental business is a key component.

Thank you for the interview.
On behalf of the Asia Pacific Dental Federation and Singapore Dental Association, we would like to invite you to attend the 37th Asia Pacific Congress (APDC 2015) to be held at the Suntec Singapore from 3 – 5 April 2015.

Themed “Meeting Future Challenges Today”, APDC 2015 will dissect some of the most controversial issues facing today’s leading health professionals from across the region and around the world.

**INVITED SPEAKERS**

- Dr. Edward A. McLaren
- Dr. Gary Glassman
- Dr. Simon Kold
- Dr. Edward A. McLaren
- Dr. Wong Keng Mun
- Prof. Iain Pretty
  and many more...

**KEYNOTE & PLENARY LECTURE TOPICS**

- The Silver Explosion – preparing oral health pathways for the next generation of older adults
- Endodontic Solutions: Scientifically Based Strategies for Performing Endodontic Treatment Predictably, Profitably and Painlessly
- Surface Scanning & Computer Guided Surgery: A hands-on course
- Hot topics in Esthetics, Dental Ceramics, and Restorative Dentistry

**WORKSHOPS**

- Dentofacial Aesthetic
- Invisalign: A marriage of Orthodontics and Technology
- World Federation for Laser Dentistry (WFLD)-Asia Pacific Division (APD)-Dental Laser Practice

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Recaldent, also known as casein phosphopeptide-amorphous calcium phosphate (CPP-ACP), is now available for MI Varnish from GC. A milk-derived protein, the product effectively remineralises tooth surfaces through bioavailable calcium and phosphate ions. This process is intended to offer general prevention for all ages, much-needed prevention for high caries risk patient groups under orthodontic treatment, as well as for patients in paedodontic or geriatric dentistry.

According to the company, MI Varnish is currently the only varnish in the market that contains CPP-ACP. Evidence supports that addition of a bioavailable calcium source enhances the efficacy of the product, offering extra protection to patients of all age groups and caries profiles to effectively relieve dentine hypersensitivity.

Owing to its texture and consistency, MI Varnish adheres effectively to the applicator brush and flows easily into difficult to reach proximal areas, while covering all tooth surfaces evenly and effectively. According to GC, it penetrates dentinal tubules effectively to form a good seal, while its neutral pH of 6.6 enhances enamel acid resistance and inhibits demineralisation. MI Varnish is claimed not to clump or coagulate when exposed to saliva, providing a creamy texture and comfortable film thickness even when multiple layers are applied.

Applied in minutes, MI Varnish is available in mint and strawberry flavours and comes in unit-dose containers that are easy to open and contain enough material for a full mouth application.

“With the new PSpIX, ACTEON offers dental practitioners a scanner that goes beyond their expectations. It will surely amaze”, a representative said. PSpIX will be officially launched at the upcoming International Dental Show in Cologne in Germany.
VATECH GOES GREEN CT

Dedicated to develop products that are beneficial for human health and the environment, dental manufacturer Vatech has been developing a sustainable manufacturing process that the it says reduces waste and pollution. Branded Green Innovation, the company has been designing and manufacturing equipment that are “low dose and low radiation”.

After the successful market launch of the Faxi3D Green in the US, devices are now manufactured and distributed under the Green CT brand. Along with this, Vatech is now introducing a new product range under the motto “low dose but now introducing a new product brand. Along with this, Vatech is and distributed under the Green CT US, devices are now manufactured and distributed under the Green CT brand.

With just 14.8 μm pixels, the intraoral sensor EzSensor Soft comes with a bendable & soft exterior that allows clinicians to achieve an accurate diagnosis of interproximal caries, for example, through improved positioning. Damage caused by commonly used rigid sensors can be reduced this way.

Isometric imaging allows for less image distortion.

Supporting the entire oral surgery process, the user intuitive Ez3D i software with the [3D PAN] tab makes everything “Quick” and “Smart”. According to Vatech, Ez3D i enables lingual-side diagnosis using volume panoramic programmes and supports effective exact location of a lesion in endodontic treatment whether it’s near the apical area or not. It also offers various modes to determine the exact bone density.

One only click is needed for a region-of-interest (ROI) diagnosis, functionality for the sensor and storage that works with UV light and minimises the risks of infection.

VATECH goes green CT

With i-Cleaner, Vatech also offers a disinfection & packaging machine automatic double wrapping functionality for the sensor and storage that works with UV light and minimises the risks of infection.

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www.vatech.co.kr/indexE
Booth SC01

CAD/CAM MATERIALS FOR OPEN AND CLOSED SYSTEMS ON DISPLAY BY VITA

With VITABLOCS for CEREC, the German company VITA Zahnfabrik introduced the world’s first ceramic for dental CAD/CAM applications in the mid-1980s. Nowadays, dental laboratories and practices have a comprehensive range of feldspar, glass, hybrid and oxide ceramics, as well as machinable polymers at their disposal.

In order to facilitate flexible, simple and reliable use of VITA CAD/CAM materials beyond the confines of an individual system, networks with selected partner companies are constantly developed and supported. In terms of closed systems, VITA CAD/CAM restoration materials are not just available for CEREC/inLab from Sirona, but also for Ceramill Motion 2 from Amann Girrbach, KaVo ARCTICA and Everest from KaVo Dental, and Core3d. In regard to open system components, VITA has established collaborations with CAD and CAM software manufacturers such as 3Shape, exocad, Dental Wings, Delcam and OPEN MIND/FLOW-ME.

Processing can be carried out using different systems, because VITA blanks are provided in different geometries (blocks and discs) available with modified block holders or adapters.

“Customers should always know when they are working with a VITA product, so in case VITA material is used by a partner, you can be sure that you really get VITA. Holders, inscriptions and packaging are adapted according to the relevant partner company. When it comes to VITA materials, users can rely on the fact that regardless of the system, they are always assured of the characteristics and qualities that they are familiar with from the various superior quality VITA CAD/CAM materials,” Product Marketing Manager Patrick Bayer explained.

In addition to the universal block materials that can be used with all standard (adapter) systems, Vita has introduced pre-colored highly translucent zirconia discs in the shades A1, A2, A3, as well as the zirconia-reinforced lithium silicate material VITA SUPRINITY for Ceramill Motion 2, Core3d and KaVo Everest/ARC TICA last year. Validation programmes with new network partners are also underway.

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