The emirate of Dubai has again become the centre of the international dental community with the start of the next edition of the UAE International Dental Conference and Arab Dental Exhibition (AEEDC) this week at the Dubai International Convention and Exhibition Centre for dental professionals from around the world. Held under the patronage of Sheikh Hamdan bin Rashid al-Maktoum, Deputy Ruler of Dubai, the event is not only the largest gathering of dental participants in the MENASA region, but also the most prominent showcase of the latest in science, technology and products for dentistry.

This year, the international show is being held in Dubai for the 18th time. According to the latest estimates, over 600 dealers and manufacturers from the region and abroad have registered for the global dental exhibition. Among innovations such as new and improved dental materials and equipment, a vast number of advanced digital solutions are on display, which were developed to improve the workflow and communication between dental practices and laboratories for the benefit of patients. Current issues and methods in dentistry will be discussed during the conference, which will see clinical presentations by more than 130 local and internationally well-known speakers. A number of specialised courses were offered again this year prior to the congress as part of the Dubai World Dental Meeting.

In addition, a student competition will be held among participants from universities in the United Arab Emirates, Saudi Arabia, Libya, Egypt, Oman, Yemen and Russia. Awards will be given for research and other contributions to oral health, as well as for best booth design and activities, among other categories.

“AEEDC Dubai 2014 will yet again supersede its previous records and achievements by delivering another outstanding event,” AEEDC Executive Chairman Dr Abdul Salam al-Madani said. “On behalf of the organisers of AEEDC Dubai and its team members, I would like to extend a warm welcome to all members of the oral health community and encourage them to seize this opportunity and benefit from the latest advances in dentistry.”

The conference and exhibition are being held from 4–6 February. A part of the Global Scientific Dental Alliance and World Dental Exhibitions Alliance, the event is organised by INDEX Conferences and Exhibitions in partnership with the Dubai Health Authority annually. Last year’s edition attracted more than 30,000 dental professionals from the Middle East and abroad, according to INDEX figures.
"Improvements in the oral health of Arab nations are definitely needed"
An interview with Prof. Manal A. Awad

At the upcoming AEEDC Dubai, Prof. Manal A. Awad from the University of Sharjah’s College of Dentistry in the United Arab Emirates will be holding a presentation on the relationship between the body mass index and periodontitis in diabetic patients. In this short interview, she gives new insight into the state of oral health in Arab countries, and why more research is needed to address oral health care needs.

Today international: Prof. Awad, how would you generally describe the state of oral health in the Arab world right now, and what are the most common features most countries share? Cultural values appear to have a significant impact on health in general. For example, in the Arab world, loss of teeth is still widely accepted as part of ageing. This should not be the case, especially with the observed increase in life expectancy. Accordingly, raising the public’s awareness about oral health and its effect on general health should be highlighted better by health care professionals. Improvements in the oral health of Arab nations are definitely needed.

What are the main differences with regard to oral health? Differences among Arab countries are mainly evident in the utilisation of health care. Financial considerations may have a significant impact on people seeking health care and this is particularly true for oral health care, which is seldom covered by insurance. However, in countries where oral health care is free, it is evident that people are more likely to visit dentists for treatments that could be regarded as more advanced and probably more expensive.

Living standards have increased in the Arab world in the last decades, at least in most of the Gulf states. In your opinion, has oral health kept up with this development? There are known oral health problems, such as the relatively high prevalence of dental caries among children in most Gulf Cooperation Council (GCC) countries. Although there is ample data showing the extent of oral health problems among these children, more efforts are needed to reduce the incidence of dental caries in these early age groups. Efforts should include oral health promotion and education of parents and children about proper methods to maintain good oral hygiene.

For effectively reducing the burden of dental caries and periodontal disease, community engagement is very important. At the upcoming AEEDC Dubai, Prof. Manal A. Awad from the University of Sharjah’s College of Dentistry in the United Arab Emirates will be holding a presentation on the relationship between the body mass index and periodontitis in diabetic patients. In this short interview, she gives new insight into the state of oral health in Arab countries, and why more research is needed to address oral health care needs.

What can new studies contribute to the improvement of oral health in the Arab world? Studies that address oral health needs among adults and elderly groups of patients are important for planning future health care. More research can provide much-needed evidence for policymakers to implement oral health programmes that address those who need them most.

Decisions made based on research conducted in other countries, however, may not provide an accurate picture about outcomes of certain interventions. For example, in planning oral health promotion and education programmes, understanding cultural values, beliefs and social structure in the Arab world is important. Culture-specific values influence patient roles and expectations, and these must be taken into consideration when planning interventions that intend to change people’s behaviour to improve their health.

Thank you very much for the interview.
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Changes in the oral health workforce: More prevention, public health and leadership

By Dr Jack Dillenberg, USA

While great progress has been made in the prevention of dental caries, the global incidence and prevalence of oral diseases has not diminished, especially among children. There are many preventive interventions available, including fluoridation, dental sealants, fluoride varnish, regular dental visits and good oral hygiene that can effectively reduce tooth decay and periodontal disease.

Current research and practice have continued to underscore the continuing lack of oral health maintenance among many groups throughout the world. Unfortunately, the low priority that is placed on oral health among many individuals from diverse cultures continues to affect the universal implementation of these effective and inexpensive measures negatively.

There is increasing evidence to support the association between oral health and systemic or overall health. The association between periodontal disease and a variety of systemic illnesses continues to emerge and underscores the need for an interdisciplinary approach to address both oral health and general medical care. These numbers are amplified in low income, disabled and other underserved groups. In the US, federal and state financial support for oral health services for low-income populations and those with complex medical conditions or intellectual disabilities continues to erode.

The ageing of the dentist population, projected retirements and maldistribution of providers coupled with an increasing population support the projections of significant provider shortages in the decades to come. Health professions in general and the dental profession in particular have to recruit, educate and promote a new kind of health provider, one that is community minded, service oriented with leadership skills and committed to interprofessional collaboration and utilizing innovative technology (such as SMS) to meet the compelling societal needs the health system requires. This includes behavioural health, social determinants of health and population-based health issues, in addition to the traditional dental issues of the past.

So what does this mean for the future of oral health care delivery, the type of systems that should be in place and the type of dentist needed to meet these needs? How will the dental professional workforce have to change to address the health and societal issues affecting health and wellness throughout the world?

The selection of dental school candidates in years past focused on candidates that were analytical and had a strong science background with good hand skills. The anticipated outcome after graduation from dental school was establishing a solo private practice in the geographic area of their choice. Not much attention was paid to community service or volunteer experience, leadership skills and an understanding of basic public health principles. The current societal needs and demands are changing the skill sets needed for success as a dentist and the practice environment in which dental graduates will find themselves.

Dental school applicants today must have the academic prowess to succeed in the rigorous science courses they will take in dental school, but they must have other critical skills to succeed and flourish. Dental students will now learn to a level of competency, not just productivity; they will treat patients with special needs, collaborate with other health professionals in friendly interdisciplinary settings, and participate in community-based activities to develop the communication and leadership skills to thrive in an interdisciplinary work environment.

This new culture of health care delivery incorporates prevention and personal responsibility for an individual’s health and well-being. The new dentist will have to be comfortable practicing in this environment, utilizing skills, training and experience reminiscent of the stomatological training of physician-dentists of the past. Dr Norman Gevitz, a historian of the stomatological movement in American dentistry, notes, “Today’s dentists need to be more broadly trained in general medicine and public health in order to more effectively respond to the oral and other related health needs of their patients and the larger community.”

This Wednesday, Dr Jack Dillenberg will be presenting a paper during the Dental Education Problems and Solutions Session, which is part of the AEEDC Dubai 2014 scientific programme. He is currently President of Dillenberg & Friends, a health services consulting provider in the US.
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Root canal instrumentation is one of the major tools for ensuring the long-term success of root canal therapy. The aim is to mechanically disrupt as much biofilm as possible so that with the addition of irrigants and/or intra-canal medicaments a very low microbial count can consistently be achieved before the filling of the root canal. Another aim or challenge of root canal instrumentation is to achieve the microbial reduction goals mentioned above without unnecessarily weakening the root by over-instrumentation, for example through the reduction of the dentinal wall thickness. Preservation of native structure, especially in the cervical region of the tooth has been demonstrated to correspond to better long-term survivability from a loading and restorative standpoint. It is well established that as the remaining dentine thickness decreases so does the root’s resistance to fracture.

In evaluating anatomical studies, it is striking that they are consistent. Figure 1 best summarises the anatomical aims for a mandibular molar. The mesiobuccal and mesiolingual canals are at the 1 mm measurement from the apical foramen, which corresponds most closely to the dentino-enamel junction. In the mesiodistal direction, the diameters are 0.21 and 0.28 mm respectively, thus finishing at a 25 file would appear to be sufficient when viewed on a periapical radiograph, since the mesiodistal direction is what we see on the radiograph. However, when we look in the buccolingual direction, the correct files sizes are between 35 and 40. For the distal canal, a size 35 would appear adequate on the radiograph (mesiodistal view) but the correct size would be 50.

In order to achieve the goals mentioned above, we should aim for 35, 40 or 50 apical sizes with no more than a 0.04 taper. These biological sizes with the addition of an adequate irrigation protocol will ensure a consistently low microbial count for maximal success.

**BT-Race system**

BT-Race files (FKG Dentaire) are sterilised in individual blisters so that sterility is maintained for...
every file. The biological sizes mentioned above can be achieved with three files every time once a glide path has been established. The system was designed in such a way that these sizes are attained with minimal removal of dentine coronally to maintain the strength of the root. Moreover, the Race file has a non-screw-in design and triangular cross-section to increase flexibility and cutting efficiency. It is also electropolished to decrease the effects of torsional and cyclic fatigue (Fig. 2).

The Booster Tip (BT; Fig. 3) is the key feature of these files however. It allows them to follow curvatures in canals without undue stress on the file or the root. The BT starts as a non-cutting tip from 0–0.15 mm diameter and the cutting edges start from 0.15 mm and upwards on the file (Fig. 4).

Essential steps for the successful use of the BT-Race sequence are the following:

Glide path

In order to guarantee a minimal number of file breakages, a glide path to size 15.02 is essential. Hand files can usually achieve this aim. However, if a 6 or 10 file is extremely difficult to take to working length, ScoutRace files allow one to achieve this requirement more quickly.

Speed of 800–1,000 rpm

A high speed reduces the risk of breakage due to torsional fatigue. As these files are for use with individual patients, the possibility of breakage from cyclic fatigue is also reduced.

BT1 (10.06 file)

This file (Fig. 5) establishes the final glide path and determines the coronal diameter. In any canal in which a 15.02 glide path has been established, the file will contact mainly the coronal third of the canal. At 12 mm from the working length, the diameter will be 0.82 mm.

These files have no BT, since the tip diameter is already 0.50 mm and smaller than the glide path established with a 15.02 K file.

BT2 (parallel 35 file with BT)

The BT2 file (Fig. 5) is used to prepare the apical third of the canal. It is extremely flexible owing to its non-tapered design, yet penetrates into the narrow canal easily and efficiently with the BT.

BT3 (35.04 file with BT)

This file (Fig. 5) is used to join the coronal and apical preparations created by the BT1 and BT2 files and thus create a 35.04 final shape that allows maximal irrigation and a tight cone fit. The file is able to go to working length with minimal stress, since the coronal third has been cleared with the BT1 file and the apical third with the BT2 file. Importantly in this canal, the maximum diameter at the 13 mm level is 0.83 mm. Consequently, the removal of coronal dentine is minimal, allowing for the strongest root possible after restoration.

BT-Race XL: BT 40 (40.04 file) and BT 50 (50.04 file), 600–800 rpm

These two instruments (Fig. 6) enable finishes at ISO 40 and 50 when adequate apical sizes require larger sizes. If even larger apical preparations than ISO 50 are required, the Race range of instruments is recommended in the required sizes, preferably with a small taper of 0.02.

With this unique file system, all canals can be conservatively instrumented to the correct biological sizes while maintaining maximum cervical tooth structure. The BT ensures that the original canal shape is maintained, thus keeping even the larger files centred in the canal. Through this advantage, in addition to the minimal taper required to achieve these biological sizes, the canal is maximally cleaned without weakening or stressing the root.
“Reach a point where dental restorative materials are rare for everybody”

An interview with Christopher H. Fox, Executive Director of the International Association for Dental Research

The adoption of the Minamata Convention in Japan recently made way for a ban on mercury-containing products on a world-wide scale. Provision was also made for phasing down the use of and trade in dental amalgam. Dental Tribune International had the opportunity to speak with the Executive Director of the International Association for Dental Research (IADR), Christopher H. Fox, who attended four of the intergovernmental negotiating committee sessions on behalf of the dental profession, about the impact this could have on dentistry and the future of dental amalgam as a restorative dental material.

DTI: The recently adopted Minamata Convention on Mercury includes provisions on phasing down dental amalgam on a global scale. What impact do you think this will have on the dental community and particularly restorative dentistry in the long run?

Christopher Fox: I think it must be first pointed out that the Minamata Convention is a very broad treaty designed to reduce all use of and international trade in mercury, as well as the demand for mercury in products and processes. In addition, it is intended to address the need for the reduction of atmospheric emissions of mercury, as well as mercury releases on land and in water.

Dental amalgam is included in the treaty as a mercury-added product contributing to the global demand for mercury. In this regard, it is important to note that the treaty calls for phasing down the use of dental amalgam, as opposed to phasing out or banning the use of it. This will give the industry and profession time to make a transition and preserve dental restorative choices for our profession and patients.

One of the provisions for phasing down dental amalgam is for countries to set national objectives aimed at dental caries prevention and health promotion, thereby minimising the need for any dental restoration. A greater emphasis on prevention and health promotion is indeed welcome and will provide the greatest benefit to populations.

Another provision promotes research and development of alternative restorative materials. So, in the long run, dentistry and restorative dentistry, in particular, will have improved dental restorative materials from which to choose for their patients.

You were involved in some of the intergovernmental negotiating committee sessions in the run up to the Convention. What were the most memorable experiences in formulating the treaty, and did the outcome meet the expectations of those involved in dentistry?

The most discussed dental amalgam issue was a ban versus a phase-down. Led by the Responsible Officer for the WHO Global Oral Health Programme, Dr Poul Erik Petersen, a coalition of concerned dental organisations was able to show country negotiators that a ban would be detrimental to population oral health. Dental amalgam is a safe and effective dental restoration and remains the best restorative choice in many clinical situations or health system situations. As with any complex negotiation, the outcome has met many people’s expectations, but there are those who would have preferred a phase-out of dental amalgam and those who would have preferred no limitations set on dental amalgam.

Another area of discussion was the need for best environmental practices in dental facilities to reduce releases of mercury and mercury compounds to water and land. Dentistry must be a good steward of the environment and implement best environmental practices for dental amalgam, as well as for all other dental materials, medical waste and consumables.

You mention that in the dental community amalgam is still considered to be effective and safe. So why phase down its use at all?

Dental amalgam is a safe and effective restoration. The US National Institute of Dental and Craniofacial Research funded two large-scale randomised clinical trials on the safety of dental amalgam. They failed to find any adverse health effects. The reason for the agreed-upon phase-down is solely the environmental and health effects of mercury in the environment, not the direct health effects of the use of dental amalgam.

Mercury poisoning from amalgam is mostly found in countries where recycling of the material is insufficient. Is this not a more pressing issue that should be addressed globally?

The proper handling of dental amalgam and its waste must be adhered to by the dental profession and the health facilities in which they work. In addition to the provisions in the Minamata Convention calling for best environmental practices, there is a provision calling for dental amalgam to be used only in its encapsulated state. Only some countries require the use of dental amalgam separators and many more dental professional organisations are calling for their universal use.

Even if we were successful with our oral health promotion programmes however and could stop using dental amalgam tomorrow by the introduction of next-generation dental restorative materials, dental facilities would need dental amalgam separators in place for at least a generation as currently placed dental amalgams come to the end of their life cycle and need to be replaced.

According to the Convention, a number of products containing mercury will be banned from 2020. Do you believe that amalgam will still play a major role in restorative dentistry by that time?

Seven years is a short time frame when we are relying on a research and development pipeline to deliver improved dental restorative materials. Without being too pessimistic, a typical research and development time frame from discovery to clinical use in the pharmaceutical arena is 17 years. So, I believe dental amalgam will still be with us in 2020, but I am optimistic it will play a much reduced role in restorative dentistry.

Alternatives to mercury-containing dental filling material were discussed last year at an IADR–FDI workshop on dental materials. Is there any viable alternative, and what needs to be done to implement and sustain its use in the future?

The recently adopted Convention in Istanbul was actually a much-condensed summary of a two-day workshop held in December 2012 at King’s College London. In brief, yes, we can have much improved, innovative dental restorative materials, but it is going to take a significant commitment from government funders, academia and industry. Keep in mind that even if a new material could be developed within a one- or two-year time frame, clinical safety and effectiveness trials and regulatory approvals will take significantly more time. Practising dentists have an important role here too, as they can participate in research networks evaluating new materials and identifying research questions, to mention advocating for research funding with policymakers in their country.

For a more complete answer to your question, I would refer your readers to the proceedings, which have just been published in the November issue of the Advances in Dental Research, an e-suppement to the Journal of Dental Research.

With the advent of preventative dentistry, stem cell research and the sophistication of tooth replacements, will restorative materials become obsolete someday?

Dental restorative materials are already obsolete or nearly obsolete for the socially advantaged post-fluoride generation. Our greatest challenge is addressing the oral health needs of socially disadvantaged and vulnerable populations. The IADR has a research agenda to reduce these oral health inequalities across populations and hopefully we will reach a point at which dental restorative materials are rare for everybody.

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Current perspectives on oral surgery

How to improve consistency and implementation of contemporary treatment recommendations and options in general dental practice

By Dr Ziad Noujeim, Lebanon

The term “surgery” is derived from the Greek words “cheir” (hand) and “ergos” (work). According to this etymology, surgery should include any clinical work implemented with our hands. In daily clinical practice, however, the use of this word is often limited to practical therapeutic acts, such as those involving cutting soft tissue (incisions), flap raising, osteotomies and reconstruction, as well as repairing and dressing living tissue. The term “oral” pertains to the mouth (or oral cavity), and oral surgery would consequently encompass maxillary sinus membrane lifts, onlay and inlay bone grafts, the placement of dental osseointegrated implants, exodontia (including surgical extraction of impacted teeth and tooth-like structures), as well as the incision and drainage of cellulitis, just to name a few. Despite these different fields of use, the limits of oral surgery are not yet well defined and may reach maxillary sinus grafts, a term that implies a greater scope of surgical interest, such as temporomandibular joint surgery, orthognathic surgery, the treatment of head and neck trauma, as well as cancer surgery.

General dental practitioners are only required to undertake surgical treatment of teeth, tooth-like structures, and soft tissue surrounding teeth. In this regard, the UK General Dental Council defines “surgical dentistry” as those surgical procedures within the mouth which would normally be accomplished for a cooperative patient under local anaesthesia, with or without sedation, in a tolerably short operating time.

In the past 30 years, oral surgery has progressed significantly in the diagnosis and treatment of dental and jaw pathology. Dentistry, particularly surgical dentistry, is rapidly changing and evolving, and dentists worldwide are attempting to adapt to the revolutionary changes and new opportunities resulting from globalisation of dental and medical surgical specialties. New insights and discoveries related to oral surgery are indeed astonishing and many of them have already been applied in everyday practice, and addressed in textbooks and at international conventions.

The near future will probably witness Er:YAG laser bone ablation replacing surgical drill osteotomy in oral surgical practice. Indeed, scanning electron microscope observations have determined that Er:YAG laser treatment produces well-defined edges. Melting and carbonisation and charring effect of classic carbon dioxide lasers could not be observed on sites irradiated with Er:YAG lasers. In addition, Fourier transform infra-red spectroscopy revealed that the chemical composition of bony surfaces after ablation with an Er:YAG laser was almost the same as that after conventional drilling with a bur, proving that the use of Er:YAG laser ablation can be an alternative to traditional bur ablation in oral and periodontal osseous surgeries, particularly in mandibular ramus onlay block harvesting, apicectomy, cysts and benign jaw tumour surgery, or the irradiation of bisphosphonate-associated jaw osteonecrosis.

Dental pulp stem cells (DPSCs) can nowadays be cryopreserved and stored for years, while still retaining their multipotency and bone-producing capacity. These highly specialised cells show very low morbidity and are easy to collect from extracted wisdom teeth or buds, for example. They also interact with bone biomaterials and substitutes, which makes them an ideal cell population for jaw reconstruction. In addition, stromal bone-producing DPSCs, a multipotent stem cell subpopulation of DPSCs, are capable of differentiating into osteoblasts, and they are claimed to possess immune privilege and exert anti-inflammatory abilities like many other mesenchymal stem cells.

CBCT, which was introduced in the late 1990s, is becoming the main imaging armamentarium of oral surgeries, as it provides more comprehensive anatomical information and data that help to improve preoperative and peroperative clinical implementation of the extraction of impacted teeth, cystectomies, removal of benign jaw tumours and placement of dental implants.

While oral surgery continues to develop further with new technologies and visions, the assessment and diagnosis of patients will still form the cornerstone of any surgical specialty. Decision-making, a complex cognitive process that involves consideration of surgical patients’ complaints and preferences, as well as the availability of evidence-based data, as well as practitioners’ case-specific clinical judgement, consequently remains an ongoing challenge for oral surgeons and dental general practitioners alike.

Inter-clinician variability and disparity in decision-making are very well known in dentistry and medicine.5–7 In oral surgery, treatment recommendations, options and decisions can vary wildly among practising dentists. In many cases, they are based more on personal values and expertise than on objective, rigorous or evidence-based analysis of treatment alternatives, risks, prognosis and benefits. There are treatment guidelines for the management of impacted teeth but none for aggressive and relapsing jaw cysts and odontogenic tumours, for which documented long-term treatment success has not yet been achieved. Owing to this lack, the treatment planning process in oral surgery remains a dilemma and warrants further interest and research.

As a matter of fact, regional differences in training, education, and dental school treatment philosophy, the “schools effect”, may significantly influence decision-making processes.5,8 It seems likely that specialists are much more confident in their ability to manage surgical cases successfully. A better understanding of inter-clinician variability in collaborative decision-making will help oral health communities in improving consistency and implementation of oral surgical treatment recommendations and options.

One of the most promising approaches is probably the non-surgical medical treatment of tumours and lesions of the jaws, as reported by Marx and Stern in 2003.9 They found a 65 per cent rate of complete resolution of central giant cell granulomas (CGCGs) in the jaws through intralesional corticosteroid injections. Demethasone and triamcinolone are currently the most popular intralesional steroids, and are very effective in CGCGs. At the same time, these are common practice not only for CGCGs but also for solitary jaw-bone lesions of Langerhans cell histiocytosis, a proliferative disease of the macrophage/dendritic cell lineage.

CGCGs, considered troublesome pathologies, are also currently medically managed by calcitonin, a polypeptide hormone produced in humans primarily by parathyroid cells in the thyroid gland, C cells. Calcitonin is known to counteract parathyroid hormone, inhibit osteoclast activity and increase calcium influx in bones. In this regard, salmon calcitonin, which is used in post-menopausal osteoporosis, hypercalcaemia, Paget’s disease and bone metastases, is considered to be more active than human calcitonin and to be an important tool in the medical treatment of jaw tumours and lesions. The main question is whether intranasal salmon calcitonin is as effective as subcutaneous human calcitonin in the medical treatment of CGCGs of the jaws.

Finally yet importantly, many clinicians and clinical investigators believe in the radical treatment of ameloblastomas, odontogenic tumours well known for their aggressiveness and high recurrence after conservative treatment. For these reasons, en bloc resection for large tumours, which includes a resection of at least 1–2 cm of normal sound jawbone beyond the tumour’s margin, is recommended. However, this surgical procedure is unacceptable in children with growing jaws though because segmental resection often leads to jaw deformity and dysfunction, which in turn may hamper physical growth and the mental well-being of the child/adolescent.

At the very least, conservative treatment of an ameloblastoma, if indicated, will allow the uncontrolled growth of the jaw to be finally completed.9,10 Considering that the majority of ameloblastomas in children are unicystic and have a very low rate of recurrence,11 they can be managed by enucleation, a conservative form of surgical treatment.12

This Friday, Dr Ziad Noujeim will be giving a presentation on oral and maxillofacial surgery as part of the science programme of AEDDC Dubai 2014. He is a currently Director of the Oral Pathology Postgraduate Scientific Programme of the American University’s School of Dentistry in Beirut in Lebanon.
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Biolase could become the next Intuitive Surgical

An interview with the company’s CEO Federico Pignatelli

What people need to realise is that BIOLASE is a cutting-edge technology company with a new technology that is potentially going to revolutionise how dental surgery is performed and practiced. As a new step in informing the marketplace about WaterLase, we have recently embarked on a social media and press campaign to reach out to millions of patients to educate them about the many advantages of being treated with BIOLASE’s technology.

We are glad to have Dr Fred Moll, the co-founder of Intuitive Surgical, who values our technology such that he joined our board of directors recently. He is a legend in the medical field because with his company he transformed the way surgery is approached through the use of robotics. Thanks to a visionary like him, today tens of thousands of patients with cancer can be treated in a much more precise way than ever before.

We believe BIOLASE has a technology that is so advanced and revolutionary that the company could become the next Intuitive Surgical. That is because with WaterLase technology we can transform surgical dentistry for hundreds of thousands of dental practices around the world, while providing better and safer care for patients.

Why do you think lasers and particularly WaterLase will be the technology of choice in dentistry for the future?

If you think about it, dentistry has not really changed very much since the dental drill was invented by the Egyptians 7,000 years ago. The principle of removing tissue by mechanical rotation has remained the same since that time, with the only major change in the past 70 years being the attachment of a high-speed engine. With WaterLase technology, we are able to make use of the most basic element of human tissue, water. The human body in its entirety consists of 60 per cent water, so water can be found in almost all tissue. Dentine, for example, has 20 per cent water in it. By energising water molecules with a laser, tissue can be cut without pain, heat, abrasion, vibration, or the risk of microfractures. At the same time, it is also much more precise. Clinically, this is much better dentistry.

Furthermore, there is no need for any anaesthetic for the patient; 99 per cent of patients can be treated without using Novocaine. How wonderful is that? Top of that, laser energy kills bacteria, viruses and fungus, and that provides another advantage for dentists, since it is almost impossible and certainly very costly to have surgical instrumentation like dental burs and endodontic files fully sterilised, and too costly to use new instrumentation for every patient to be treated.

With all these advantages, why does it seem that the technology has not been adopted widely by dentists yet?

That is not exactly true. Since the introduction of WaterLase technology 15 years ago, we have sold over 10,000 units worldwide, 6,000 of which were in the USA alone. The main challenge however is education. Dentists need to be better educated about the return on investment and the system’s extensive clinical advantages in comparison with conventional dentistry.

In fact, only two and a half years ago, WaterLase technology for the very first time broke the speed barrier, which means that it now cuts as fast as a conventional dental drill, sometimes even faster. Furthermore, it allows impressive treatment and cutting of soft tissue, which is something a dental drill cannot do. These additional options mean that dentists no longer need to refer patients to a specialist for these tasks, thereby boosting revenue in the practice.

Where do you see the technology in the next five to ten years?

In contrast to other market-leading systems or technologies, such as Sirona’s CEREC, WaterLase is protected by over 100 patents, which will allow us to protect our competitive advantage. The adoption cycle of new technologies is growing increasingly shorter and more advanced technologies like WaterLase will rapidly find their way into dental practices. Dentists that do not upgrade their practices will likely begin to lose patients, become uncompetitive and lag behind. You cannot fight technology; you cannot fight innovation. If you do, you are doomed to be left out of the market.

We regularly ask patients whether they would like to be treated by a conventional dentist or high-tech dentist, and almost 100 per cent of patients would like to be treated by a high tech dentist. Therefore, we believe that WaterLase will be part of most dental practices in the near future.

Thank you very much for the interview.

Federico Pignatelli
Digital technologies have become powerful tools for dentistry

By Dr Rodrigo Castillo, Spain

Digital technologies are universally present in almost every aspect of our lives. In dentistry, they have provided us with powerful tools for diagnosis, treatment planning and communication. As computers are becoming an essential part of state-of-the-art patient care, clinicians must stay up to date with this rapidly developing field in order to make informed choices in their use of technology.

When applied effectively, clinical software can help to improve efficiency and patient satisfaction to a large degree. Digital photography, high-definition video and advanced presentation software, for example, allow us to design a virtual aesthetic treatment plan. With the Internet, there is the possibility of sharing and reproducing any design with any device that runs the same software. Moreover, the ever-increasing storage capacity in this virtual world allows access to information from anywhere around the clock through Internet-capable devices, such as laptops and tablet computers. Communication and connectivity are the new cornerstones of modern dental practice.

Two of the most important contributions from the digital field for dentistry are clearly CAD/CAM and CBCT, which allows a 3-D view of the treatment site. This provides greater accuracy in implant planning for greater predictability and success of the treatment outcome, for example. The two technologies combined also allow the fabrication of custom-made surgical stents, which give clinicians better control in placing implants in a prosthodontically driven way.

Clinicians must be cautious, however, when designing a treatment plan, as an increasing number of patients are demanding minimally invasive dental procedures. The common denominator here is tissue preservation. In this regard, digital technologies help to enhance non-invasive or flapless surgeries.

Virtual planning procedures have become more intuitive with guided surgery software. Two of the requisites of such software are user friendliness and evaluation of the precision of both surgical and prosthetic components, thus achieving prosthodontically driven implant treatment. In addition, such software allows sharing of the planning information among the dental team, which facilitates the decision-making process. The advantage of being able to present the treatment plan to patients on a large screen makes it an excellent tool for presenting oneself as a modern dentist.

Despite the new treatment possibilities that come with digital technology, however, important scientific criteria must still be taken into account when creating a virtual treatment plan in order to avoid pitfalls during the execution of the prosthodontic or surgical dental procedures. Therefore, a treatment protocol that combines digital and traditional concepts is recommended.

This Wednesday, Dr Rodrigo Castillo will be presenting a paper on modern virtual dentistry as part of the scientific programme of AEEDC Dubai 2014. He maintains a private dental practice focusing on oral rehabilitation in Murcia in Spain.
Minamata Convention bans products, Agrees to amalgam phase-down

Dentists prone to visual illusion

Dental memories haunt brains

Minamata Convention bans products, Agrees to amalgam phase-down

Certain products containing mercury will be banned from 2020, according to a new international treaty signed in Minamata in Japan. The regulations apply to the production and trade of batteries, cosmetics and fluorescent lamps containing the toxic material, among other products. Amalgam dental fillings are not affected by the ban.

However, the treaty agreed on a number of provisions on the phasing down of the controversial dental material. The Convention, which was proceeded by five inter-governmental negotiation rounds and ended with a historic signing at a meeting in Geneva in January, was signed by 87 countries. Governments now have three years to develop and implement national strategies to reduce or eliminate the production and industrial use of the toxic metal. Mercury emission from large-scale industrial plants, the main source of mercury pollution worldwide, will also be controlled.

Dental associations reacted positively to the decision, which will permit the use of amalgam as a restorative dental material for the years to come. Dr Stuart Johnston from the British Dental Association, who took part in the negotiations on behalf of the FDI World Dental Federation, commented: “We are delighted that the Minamata Convention allows the dental profession continued access to a key restorative material. Dental amalgam is safe and effective: it has been in use for over 150 years and no situation has demonstrated any harm to human health.”

He said that despite amalgam not being banned by the treaty, however, the dental profession is committed to phasing down the use of the material through the prevention of dental diseases, the development of alternative materials and effective amalgam management. Guidelines in this respect for professionals, health officials and the public are currently being compiled and will be released by the organisation soon. The initial steps have already been taken with a pilot project launched recently by the FDI in partnership with the United Nations Environment Programme in East Africa that aims to train professionals in the country on managing and recycling amalgam waste more effectively.

Amalgam remains one of the most widely used restorative materials worldwide. Particularly in developing countries, it is often the only affordable means of treating dental caries, despite the availability of other methods, such as armament restorative treatment. Unfortunately, it is also a significant source of mercury pollution. Recent national tests conducted in Pakistan, for example, found that levels in urban dental hospitals and practices were up to 20 times higher than acceptable levels, which was considered largely due to poor amalgam waste management.

According to estimates by the United Nations Environment Programme, between 300 and 400 metric tons of mercury is used in dental fillings every year worldwide, a tenth of the world’s annual consumption.

Dentists prone to visual illusion

Objects in a mirror appearing to be farther away than they are is a common illusion encountered by car drivers around the world every day. Misleading visual perceptions of an object could also be the reason that dentists sometimes drill larger cavities than necessary to fill a tooth or prepare a root canal, a team of psychologists and dental researchers from Australia and New Zealand has suggested.

In clinical field tests involving eight practising endodontic specialists from New Zealand and conducted in 2002 and 2004, the researchers found that dental professionals tend to fall trap to the Delboeuf illusion, which makes enclosed areas appear smaller than they actually are when seen in a larger context. The illusion was first documented in 1865. It has been reported to be used by restaurants to trick customers regarding the size of their dishes by using smaller plates, among other things.

“Recent studies have indicated that the caudate nucleus, including the caudate nucleus, may play a role in learning and memory functions. The subjects in the dental fear group therefore may be receiving feedback from memories of sounds of dental treatment,” researcher Hirofumi Karibe from the Nippon Dental University’s Department of Pediatric Dentistry in Tokyo suggested. He said that the findings, which have not been published yet, could be applied to assess the effectiveness of conventional interventions for dental fear, such as cognitive-behaviour therapy.

The study is the first to have measured how the sounds of dental instruments relate to brain activity. It confirms the assumption that dental anxiety is mainly due to reasons other than the fear of experiencing pain through surgery.

Dental memories haunt brains

The sound of a dental drill or suction system evokes a feeling of fear in almost every tenth dental patient. New findings presented by Japanese researchers at a recent neuroscience meeting in the US have revealed new insights into how the brain of anxious patients may react during treatment.

Using functional magnetic resonance imaging, a neuroimaging procedure to measure brain activity, the researchers found stronger activity in the left caudate nucleus in anxious patients when playing them sounds of various dental instruments. When neutral sounds, like a French horn or pure tone, were played, however, activity in this region was found to be significantly lower.

No significant neural activity was detected when the same sounds were played to a control group of non-anxious patients. Instead, these patients showed stronger brain activity in the right and left superior temporal gyrri, a part of the brain usually associated with auditory processing and other neural functions.

“Recent studies have indicated that the basal ganglia, including the caudate nucleus, may play a role in learning and memory functions. The subjects in the dental fear group therefore may be receiving feedback from memories of sounds of dental treatment,” researcher Hirofumi Karibe from the Nippon Dental University’s Department of Pediatric Dentistry in Tokyo suggested. He said that the findings, which have not been published yet, could be applied to assess the effectiveness of conventional interventions for dental fear, such as cognitive-behaviour therapy.

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With Coreflon, the Polish company Implacore is offering a new surgical suture with various benefits for clinicians and patients. Head of the Implacore's R&D department and oral surgeon Dr Jaroslaw Pospiech spoke about the product and the advantages it offers for oral surgery.

Dr Pospiech, what makes Coreflon unique?
Dr Pospiech: Our new PTFE surgical suture Coreflon was created in response to the increasing interest in the implantology and plastic surgery market. It is the first smooth PTFE surgical suture (dPTFE) without micropores. This reduces dental plaque adhesion and accumulation of bacteria and food residues very effectively. The softer thread ensures maximal reduction of tissue micro damage and is easy to remove owing to the lower capillarity.

The product also offers benefits to the patients in form of a durable surgical knot that does not loosen. Moreover, the ends of the suture do not cause irritation of the chin, lips and tongue.

Does the type of thread and needle really matters that much?
The variety of suture materials and needles available on the market can be overwhelming and therefore choice for a specific suture is often-times based on personal preferences. The idea of using a black needle was taken from cardiovascular surgery, where it has been used owing to its non-reflective surface and higher contrast it has against the blood and soft tissues. Our surgical needles are made of very high quality steel, that combined with a white PTFE, provide excellent visibility in the surgical field.

How long did it take from the concept to the launch of the product?
We spend almost three years on the development of the final product. Coreflon was certified by TÜV Rheinland in Germany, one of the most stringent notification bodies in Europe, and meets all standards of medical directive. Each thread is subject to quality assessment resulting from the quality standards. These controls and rigorous testing procedures are supposed to guarantee a reliable product of a excellent quality.

Have you received any feedback from users of the product? So far, the feedback has been very positive as you can see from most of the comments posted on our website. Most users are reporting that it is a very good and versatile product which is amazing to work with in comparison to other market leading brands. Doctors are also content with the excellent properties of Coreflon, especially with the thread's ability to stretch and to return to its original shape.

What are your plans for the future of Coreflon? We offer a reliable, versatile, innovative and price attractive product. Implacore is now focused on developing and manufacturing a wider range of Coreflon sizes. This will result in better options for dentists and better solutions for patients. Stay tuned!
Schedule of scientific presentations

Tuesday, 4 February

9:30–10:15 Designing the abutment of implants in the aesthetic zone—New perspectives, Conference Hall B
Speaker: Stavros Pelekanos

10:15–11:00 How to maintain oral health of patients by making evidence-based oral hygiene recommendations in practice, Conference Hall A
Speaker: Guy Goffin

11:15–12:00 Updates in surgical techniques, Conference Hall B
Speaker: Bodo Hofmeister

12:00–12:45 Oral and maxillofacial surgery, Conference Hall B
Speaker: Robert Edweh

Orthodontics, Conference Hall C
Speaker: Joht-Poban

Ceramic laminate veneers and improved dental aesthetics, Part 1 (Diagnosis, treatment planning, tooth preparation, and temporization), Conference Hall D
Speaker: Tanj Fudal-Ahjazwai

12:15–12:45 Can we consider dental implants nowadays as foreign bodi-es, Conference Hall A
Speaker: Mohammad Isam Koleilat

14:00–14:30 What’s new in smile design, Conference Hall A
Speaker: Alain Méthot

Caring for our youngest pa-tients: An overview of NAM, Conference Hall D
Speaker: Vodakdhesh Prasad Sarabairiot

14:00–14:45 Oral Cancer: How to find, how to diagnose and how to treat (S3 Guidelines for General Practitioners), Conference Hall B
Speaker: Jurgen Erven

Ergonomics—Enhancing work efficiency in dentistry, Conference Hall C
Speaker: Shab Abdul Rahim

14:30–15:30 Advances in oral microbial diagnostics: A shift from cell culture and probes towards micro-biome and metagenome, Conference Hall A
Speaker: Egija Zaura

Diabetes mellitus: Strategies for providing comprehensive care, Conference Hall C
Speaker: Joanna R. Gurenlian

Solving the puzzle of caries risk and prevention in orthodontics patients (The new era), Conference Hall D
Speaker: Anas Al Mulla

14:45–15:45 Comparison between orthog-nathic surgery and distraction osteogenesis in cleft patients and their consequent speech results, Conference Hall B
Speaker: Anwar Al Khaja

15:30–16:00 Performing a successful cus-tomer (patient) relationship management system within your dental practice, Conference Hall C
Speaker: Ahmed Mosad

15:30–16:00 Current perspectives on oral traumatology: An update for dental general practitioners, Conference Hall D
Speaker: Lars Anderson

How short and narrow can dental implants be?, Conference Hall D
Speakers: Ulrich Koster & Matthias Müller

15:45–16:45 New trends in restoring en-dodontically treated teeth using resin-based materials, Conference Hall B
Speaker: Han Ounis

16:00–16:45 Handling endo-pathic patients, Conference Hall C
Speaker: Ebah Heikal

16:30–17:30 Dental trauma: Contemporary concepts in management, Conference Hall A
Speaker: Priyanshi Ritwik

Potential causes of dental bone loss around implants, Conference Hall D
Speaker: Mohammed A Alshehri

16:45–17:30 Bioresorbable endodontic fillings: Weaknesses and innovations, Conference Hall B
Speaker: Arthur Partiyiak

Minimal intervention dentistry and maximum preservation of tooth structure, Conference Hall C
Speaker: Hien Ngo

Wednesday, 5 February

9:00–9:15 Opening and introduction for the Dental Education and Solutions Session, Conference Hall A
Speakers: Abdullah R. Al Shamery & Dr. Muhammed Mustahsen Rahman

9:00–9:30 Aesthetic dentistry—Conservative approaches, Conference Hall B
Speaker: Samira Al Sabahi

9:00–9:45 The art of the smile, Conference Hall B
Speaker: Derek Mahony

10:45–11:15 Current problems in dental education and possible solutions, Conference Hall A
Speaker: Juma Al Khbaisi

14:45–15:30 Current problems in dental education and possible solutions, Conference Hall A
Speaker: Juma Al Khbaisi

11:45–12:15 All you need to know about tooth wear, Conference Hall B
Speaker: Randa Shaker

11:45–12:15 The clinical approach of the orthog-nathic canal shaping with nickel-titanium rotary instruments, Conference Hall D
Speaker: Roger Rebeiz

12:15–12:45 Dental education problems and Solutions Session, Conference Hall A
Speaker: Basem Alnaim

12:45–13:15 The difference between conventional 2-D and new 3-D X-ray diagnostics, Conference Hall D
Speaker: Ritu Kalia

13:15–13:45 Cone Beam CT in Dentistry: The difference between conv-entional 2-D and new 3-D X-ray diagnostics, Conference Hall D
Speaker: Ritu Kalia

13:45–14:15 Preventive dentistry, Conference Hall B
Speaker: Hien Ngo

About the Publisher

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Claudia Salcevici
Matthias Alschot
16:45–17:30 Zirconia restorations: Weaknesses and innovations, Conference Hall B
Speaker: Arthur Partiyiak

Minimal intervention dentistry and maximum preservation of tooth structure, Conference Hall C
Speaker: Hien Ngo

Setting up a postgraduate spe-cialty dental education pro-gramme in the UAE, Conference Hall A
Speaker: David Wray

The Challenge of Treating Con-genital Missing Maxillary Lat-erals and the Need of Multidi-sciplinary Approach—Prese-nation of the Facial Tendency in Five Family Members, Conference Hall C
Speaker: Katerina Douma

11:15–11:45 Dental education problems and solutions, Conference Hall A
Speaker: Mohammad Sabi Samed

Pink ceramics: A gingival per-spective for dental esthetics, Conference Hall B
Speaker: Joji Markose

Informed consent & refusal in dental practice: The concept & implications, Conference Hall C
Speaker: Sughu Malayil Koshy

11:15–12:00 The new generation of endodon-tic systems and management of broken instruments, Conference Hall D
Speaker: Mohammad Alqoq Amazeen

11:15–12:45 Distalize as a predictable and minimally invasive distalization approach, Conference Hall C
Speaker: Luis Carriere

14:00–14:45 Shaping for cleaning the root canal system, Conference Hall A
Speaker: Philippe Suleiman

FDI World Dental Federation: Towards optimal oral health, Conference Hall B
Speaker: Juan Luc Eziel

Progressive smile design—Pred-ictable and ethical aesthetic dentistry, Conference Hall C
Speaker: James Russell

30 years of orthognathic sur-gery: Do’s and don’ts, Conference Hall D
Speaker: Bodo Hofmeister

16:45–17:30 Cone Beam CT in Dentistry: The difference between convention-al 2-D and new 3-D X-ray diagnostics, Conference Hall D
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Current problems in dental education and possible solutions, Conference Hall A
Speaker: Juma Al Khbaisi

Full upper and lower rehabilita-tion with porcelain veneers—The happiness to smile, Conference Hall B
Speaker: Lamberto Villani

What is really possible to do with composites today, Conference Hall D
Speaker: Bodo Hofmeister

The art of the smile, Conference Hall B
Speaker: Derek Mahony

Current problems in dental education and possible solutions, Conference Hall A
Speaker: Juma Al Khbaisi
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VATECH Booth Info:
Hall 5 / Booth No. 152
Sinus lift procedures: Clinical, radiographic and histologic overview, Conference Hall
Speaker: Christian Makary
15:30–16:30
Modern virtual dentistry: A digitally futuristic approach for diagnosis, treatment planning and communication, Conference Hall D
Speaker: Rodrigo Castillo
15:30–17:30
Challenges in pediatric oral health care—Latest updates, Conference Hall A
Speakers: Ali Atta, Abdul Qaasim & Rafif Tayara
16:15–16:45
The use of Platelet-Rich Fibrin (PRF) in periodontal regeneration, Conference Hall C
Speaker: Maha Ahmed Bahammam
16:15–17:00
Marketing your dental services, Conference Hall B
Speaker: Ehab Heikal
16:30–17:30
Contemporary concepts for guided surgery with immediate implant loading as opposed to conventional implant treatment techniques for challenging clinical situations, Conference Hall D
Speaker: Peter Borsay
16:45–17:30
Immediate placement of dental implants into infected dento-alveolar sockets: When does it fail or succeed, Conference Hall C
Speaker: Wahid Tero
17:00–17:30
How to be a likable dentist in social media, Conference Hall B
Speaker: Ahmed Mostafa
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Facial blocks under ultrasound guidance, Conference Hall B
Speaker: Philip Macaire

Smear layer in endodontics, Conference Hall C
Speaker: Ayman Mandourah

Efficacy of ozone therapy in management of patients with internal derangement of temporomandibular joint, Conference Hall D
Speaker: Nasser Al Manthery
9:00–9:45
Zirconia crowns in pediatric dentistry, Conference Hall A
Speaker: Rafif Tayara

9:30–10:00
Minimizing pain during endodontic therapy, Conference Hall C
Speaker: Panos Panagopoulos

Efficacy of ozone therapy in management of patients with internal derangement of temporomandibular joint, Conference Hall D
Speaker: Mohamed Said Hamed

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Anesthesia for special care dentistry, Conference Hall B
Speaker: Kareem Abdallah Mohamed Ali

10:00–11:00
BT Race and Total Fill—A bio-logic and conservative approach for cleaning, shaping and obturation of root canals, Conference Hall C
Speaker: Gilberto Debelian

Current perspectives on oral surgery: An update for dental general practitioners, Conference Hall D
Speaker: Ziad Noujeim
10:15–11:00
Pharmacology & drug prescribing in dentistry: What should the general dental practitioner Know?, Conference Hall A
Speaker: Mohammad A. Al-Muharraqi

Marginal bone stability around maxillary single tooth implants: Leakage & micro movements effects, Conference Hall B
Speaker: Antoine Berberi
11:15–12:00
Oral health considerations among cancer survivors, Conference Hall A
Speaker: Maha Ali Al-Mohaya

Dental tourism, Conference Hall B
Speaker: Laila Al Jasmy

Prosthetic tricks to achieve predictable esthetic results in implant therapy, Conference Hall C
Speaker: Dmitar Filchov

Dental photography: Shade
analysis, redesigning the smile and lab communication, Conference Hall D
Speaker: Lamberto Villani
12:00–12:45

How bracket design and technology allow us to be better orthodontists, Conference Hall A
Speaker: James J. TenBroek

Leadership vs. management: Different roles, same goals, Conference Hall B
Speaker: Neeraj Khanna

Dental photography: Shade analysis, redesigning the smile and lab communication, Conference Hall C
Speaker: Mohamed Kotrash & Khairy Dalati

Clinical photography and imaging, Conference Hall D
Speaker: Akhter Husain

14:00–14:45

Improving facial balance and sleep apnea problems without surgery, Conference Hall A
Speaker: Derek Mahony

The endodontic glidepath: “The road to NiTi rotary safety and efficiency”, Conference Hall B
Speaker: Rashid Al Abed

Aesthetic analysis and therapy plan, Conference Hall C
Speaker: Kubais Al-Asaff

Prosthodontics, Conference Hall D
Speaker: Ziad Salameh

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Can we evaluate the biocompatibility of restorative and endodontic biomaterials in vitro and in vivo? Preclinical Approaches, Conference Hall B
Speaker: Michel Goldberg

14:45–15:30

Should the third molars be extracted in orthodontic patients?, Conference Hall A
Speaker: Sazil Poonnen

Soft skills for young new dentists – Need or no, Conference Hall C
Speaker: Periannan Pillai Pushparajan

14:45–15:45

The use of biokinograph in fixed prosthodontic, Conference Hall D
Speaker: Silvana Beraj

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Dental stem cells: A perspective area in dentistry, Conference Hall B
Speaker: Sura Ali Ahmed Fouad

15:30–16:00

State, facts, myths and downright lies, Conference Hall A
Speaker: Joanna R. Gurenlian

15:45–16:15

Periodontology, Conference Hall B
Speaker: Sultan Ahsal

15:45–16:30

Common medical conditions & their consequences for dental care: Continuing controversies, available evidence and current recommendations, Conference Hall D

16:45–17:30

Safety and Efficacy: Striking a balance in sedating anxious children for dental treatment, Conference Hall A
Speaker: Priyanshi Ritwik

Halitosis: Aetiology, symptoms, diagnosis and treatment, Conference Hall B
Speaker: Teeb Thamer AlHadithy

Ceramic laminate veneers and improved dental aesthetics, Part II (Final impression, colors selection, cementation, presentation of several complex cases, and maintenance), Conference Hall C
Speaker: Tarig Fadel Alghazzawi

17:00–17:30

The use of the lateral wall bone in sinus lifting for a 2-dimensional reconstruction: A novel surgical technique, Conference Hall D
Speakers: Antoine Berberi & Dr. Nabil Nader

Last update was 13 January, 2014. Times and topics are subject to change.
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Planmeca’s vice-president on the company’s strategic investment in E4D Technologies

Finnish dental technology manufacturer Planmeca has recently made a significant equity investment in the US-based high-tech medical device company E4D Technologies. In this interview, vice-president at the Planmeca Group and acting CEO for E4D Technologies Tuomas Lokki sheds light on this new venture.

today international: Mr Lokki, why did Planmeca choose to invest in E4D Technologies?

Tuomas Lokki: We believe in the tremendous possibilities and future growth of CAD/CAM dentistry. As dentistry will be completely digital in the future, we believe it is vital to invest in the development of new and efficient practices. E4D is a long-term leader in advancing modern CAD/CAM dentistry, so we knew that joining forces with this high-tech medical device company would be a valuable addition to our own leading expertise in 3-D imaging and software solutions. Their special expertise and innovative ideas provide a great foundation for future projects that will combine the know how of both companies.

What advantages will this investment offer dental customers worldwide?

The new partnership with E4D Technologies will enable us to offer our customers the most modern CAD/CAM innovations. Our product distribution in over 120 countries and the cutting-edge E4D innovations will increase global product availability and take computer-aided dentistry to the next level. Our customers will also benefit from the innovative combination and seamless integration of Planmeca’s and E4D’s products and services.

How will this improve the daily workflow at clinics?

One great advantage is the integration of X-ray imaging and CAD/CAM into a single software platform, Planmeca Romexis. For the first time, customers will have the option of one software interface for both X-ray imaging and CAD/CAM work. All patient data is also saved in the same database and can be shared immediately and easily through the clinic’s network or with the Planmeca Romexis Cloud service. Furthermore, the restorations designed in the CAD module can easily be combined with the patient’s 3-D X-ray images for implant planning purposes, for example. For the patients, this means convenient same-day dentistry.

Can you also tell us about the brand new intra-oral scanner that you launched recently?

Our new Planmeca PlanScan intra-oral scanner is an ultra-fast, powder-free and open solution for 3-D digital impressions. Its advanced blue laser technology accurately captures hard and soft tissue of various transparencies, dental restorations, models and impressions. It is the world’s first dental unit-integrated intra-oral scanner and can be used through a laptop as a standalone version. Together with our Planmeca Romexis software, the system supports an ideal digital treatment workflow.

How will both Planmeca and E4D benefit from this investment?

On the one hand, this investment strengthens Planmeca’s position in the fast-growing CAD/CAM business and Planmeca benefits from E4D’s cutting-edge solutions and long-term CAD/CAM expertise. On the other hand, Planmeca’s extensive distribution network enables E4D Technologies to grow globally and our leading dental imaging solutions will be a valuable addition to the E4D CAD/CAM platform.

Has this venture created any new needs for your company?

Definitely, as we need to provide extensive CAD/CAM training for our distribution and customer network in over 120 countries. Therefore, we have recently invested in new training, warehouse and production facilities alongside our Helsinki headquarters. These new 10,000 sq. m. facilities will help us address the growing need for training and education in this new field of dentistry. We are thrilled to be able to take CAD/CAM to the next level. Our innovations will change the concept of same-day dentistry completely and facilitate the workflow of dental professionals worldwide.

Thank you very much for the interview.

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INIBSA DENTAL PRESENTS RANGE OF ANAESTHETICS

In daily practice, dental professionals deal with a wide range of patients, as well as pathogens. Therefore, it is important to select the appropriate anaesthetic for each treatment and patient considering factors such as the need for postoperative pain control, the required haemostasis, the risk of postoperative self-inflicted injuries, as well as any existing contraindications to the selected local anaesthetic.

Inibsa Dental asserts that it has the right anaesthetic to suit every patient. The Spanish company offers a comprehensive range of safe, convenient and effective anaesthetics for every type of dental procedure. Its local anaesthetics are aseptically manufactured and it makes use of silicone-coated, latex-free rubber components to allow smooth and painless injection, according to Inibsa.

With over 65 years’ experience in the research, development and production of dental anaesthetics, the Barcelona manufacturer of pharmaceutical products has an annual production capacity of over 150 million cartridges, positioning it among the world’s leading manufacturers in this field.

NEW ENDODONTIC IMAGING MODE AVAILABLE FROM PLANMECA

Planmeca has introduced a new imaging mode that was developed especially for use in endodontics and in cases dealing with small anatomical details, such as imaging of the ear. The new mode, which produces extremely high-resolution images with a very small voxel size of only 75 µm, is available for all Planmeca ProMax 3D imaging units.

According to Planmeca, the new mode provides clinicians with perfect visualisation of even the smallest anatomical details. Owing to new intelligent noise and artefact removal algorithms, noise-free and crystal-clear images can be produced, the Finnish dental equipment manufacturer said. With Planmeca ARA, for example, artefacts resulting from metal restorations and root fillings in the patient’s mouth that cause shadows and streaks in CBCT images can be removed effectively. In addition, the new Planmeca AIDO Adaptive Image Noise Optimizer is intended to reduce noise in CBCT images resulting from a particularly low radiation dose or small voxel size without losing valuable details. The company said that the filter particularly improves image quality in the endodontic mode, where noise is inherent due to the extremely small voxel size. It has also proven useful when used in accordance with the Planmeca Ultra Low Dose protocol, where noise is induced by the partici- latory low dose.

Planmeca AIDO also allows the reduction of exposure values and consequently the radiation dose in all other imaging modes, according to Planmeca.

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Dental manufacturer NTI from Germany is to present new instruments at this year’s AEEDC Dubai, including cutters for achieving uniform surfaces on non-precious metals, as well as glass fibre posts and instruments for inlay preparation. The latter were designed to meet the demand for smooth cavity floors through correct functional and instrumental realisation, particularly in aesthetic solutions.

The InPrep achieves exact and super-smooth results in seconds, according to the company. It features a central inactive guide surface intended to prevent unwanted preparation at greater depths. Owing to its upright positioning, the InPrep thus maintains the set depth while the floor of the cavity is prepared to a smooth finish.

The head can be positioned according to the length of the post, which allows the post length in the root to be fully utilized without having to compromise stability of the head. The axial and lateral masticatory forces are thus completely transferred to the prepared tooth.

According to NTI, the head can also be used without a post, a feature that allows the secure fixing of a temporary prosthesis. The head can be positioned according to the length of the post, which allows the post length in the root to be fully utilized without having to compromise stability of the head. The axial and lateral masticatory forces are thus completely transferred to the prepared tooth.

NTI has also announced a revolution in glass fibre post technology with its FiberMaster TopHead. The heads were developed for the posts based on the company’s reliable conical FiberMaster to ensure secure fixation of temporary prostheses. According to the company, repeated endodontic treatment with simultaneous stabilisation of the tooth is now possible. The risk of breakage is significantly reduced, since the post is inserted two-thirds into the prepared tooth, it said.

The TopHead is intended to enable further endodontic treatment to be performed without losing the retention strength of the temporary prosthesis.

In addition, NTI said that its non-precious metal alloy cutters feature a newly developed blade configuration with perfectly uniform surfaces. With the help of an optimised cutting geometry that prevents chipping of the cutting edges, material can therefore be removed more efficiently for a longer service life. Working time is also reduced with the help of a negative cutting angle, which also guarantees a high removal rate. A gentle working pressure produces a previously unobtainable surface that makes polishing easier.

For the tenth consecutive year, A-dec has won the Townie Choice awards in the categories Best Patient Chairs, Best Operatory Delivery Systems, Best Dental Cabinetry, Best Operatory Lights, Best Stools and Best Waterline Systems. Considered the dentist’s choice for dental products and services, the winners are voted for annually by dental professionals who subscribe to the Dentaltown magazine or are registered users of its website. Established by Dr Howard Farran and Farran Media as a resource to help dentists make informed purchasing decisions, the Townie acclaim is an indication of manufacturing innovation, leadership and product reliability.

Every year since Dentaltown’s first Townie Choice awards in 2003, doctors have voted A-dec best in class across multiple dental equipment categories. Of A-dec’s six category wins this year, all but Best Dental Cabinetry began in 2003.

According to A-dec, its chairs and delivery systems are central to the company’s A-dec 500, A-dec 400, and A-dec 300 product lines. The award for the A-dec LED dental light adds to the light’s growing list of accolades, which include THE DENTAL ADVISOR’s coveted Editors’ Choice award, an IDEA Silver from the Industrial Designers Society of America, the international Red Dot Design Award, and 2012 Best New Product for Women voted by the American Association of Women Dentists, the company said.

In the dental cabinetry category, the A-dec Preference Collection also received the Townie Choice, as did the A-dec doctor’s stool and A-dec ICX for waterline maintenance.
VITA SUPRINITY® – Glass Ceramic. Revolutionized.

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VITA SUPRINITY material belongs to the new generation of CAD/CAM glass ceramics. Now for the first time this innovative, high-performance material is reinforced with zirconia. This results in a high-strength material and processing safety coupled with an extraordinary degree of reliability. It features a particularly homogeneous structure that ensures simple processing and reproducible results. And what’s more, VITA SUPRINITY offers the benefit of a very wide range of indications. For more information visit: www.vita-suprinity.com  facebook.com/vita.zahnfabrik

ACTEON is coming to Dubai with an innovation that allows dentists to detect and treat dental plaque simultaneously. According to the French dental group, the combination of its F.L.A.G. plaque disclosing and the B. LED technology featured in the NEWTRON SLIM B. LED handpiece provides amazing results with a simplified operating protocol.

F.L.A.G. can be applied directly to teeth or diluted in the tank of the NEWTRON PSXS ultrasonic generator. The plaque disclosing targets dental plaque and becomes fluorescent under the B. LED light for scaling that is more accurate, preserving tissue and allowing treatment that is less painful and time-consuming for the patient, the company said.

Dental professionals will be able to try out B. LED at the company’s booth. The technology is currently available to dentists throughout the Middle East region through dealers and ACTEON’s direct sales channels.

ACTEON GROUP, FRANCE
www.acteongroup.com
Booth 9 & 10

GC EVERX POSTERIOR SIMPLIFIES LARGE RESTORATIONS CHAIRSIDE

Short glass fibres have been shown to prevent the occurrence and spread of cracks in fillings effectively. This special feature thus makes it an ideal substructure for reinforcing composite restorations.

Catering to the growing demand for an economical restorative alternative for filling large cavities, everX Posterior from GC is a glass fibre-reinforced composite whose special material structure offers new possibilities for filling large cavities. As a reinforcing material for direct composite restorations, everX Posterior is especially suitable for large cavities in the posterior area, according to the company. As a dentine substitute, used in combination with a conventional composite as an enamel replacement, such as G-ænial Posterior, it also allows for the immediate treatment of major extended defects, which include cavities with three or more surfaces to be restored, as well as cavities with missing dental cusps. Other indications are deep cavities (including Class I and II cavities, plus endodontically treated teeth), cavities after amalgam removal, as well as cavities for which inlays and onlays would also be indicated.

According to GC, everX Posterior’s glass fibres provide minimal horizontal shrinkage and prevent fractures occurring in the final filling. Owing to the high fracture toughness of the material, which is almost twice as high as that of other composites, restorations show unprecedented strength. Fillings are also reliable thanks to its adhesive properties, both on the overlying composite and the underlying tooth structure.

GC recommends that everX Posterior always be covered with a light-curing universal composite, such as one from the G-ænial product family, in order to achieve aesthetic and wear resistance.

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At the end of 2013, dental technology provider VATECH Global reported 500 unit sales of its PaX-i imaging device to customers in the Middle East. In marking this milestone, the company has announced that it will be promoting its device and its intra-oral camera during this year’s AEEDC Dubai.

Recently, VATECH released PaX-i3D Green, its newest CBCT imaging system, which provides high-resolution images with significantly lower radiation exposure. The eco-friendly device, which was manufactured using renewable energy sources and without the use of hazardous substances, was certified by the US Food and Drug Administration for use in paediatrics, VATECH sales director S.J. Kim said. According to Kim, the unit has three separate sensors for digital panoramic, cephalometric, and 3-D imaging, as well as horizontal and vertical collimation to limit the area that needs to be scanned. He said that its fully digital CMOS sensor can capture a scan in 5.9 seconds. Owing to its high-resolution flat-panel X-ray sensor, PaX-i3D Green can even capture 3-D images at radiation doses lower than some 2-D imaging systems, he commented.

“With our PaX-i3D Green, we are leading the trend of digital imaging in the worldwide dental imaging market. We are continuously challenging ourselves in terms of product development and customer satisfaction to remain the number one company in this field,” Kim said.

According to VATECH, the company has revolutionised the dental X-ray market with innovative technologies, such as Magic Pan, a reconstruction technology for high panoramic images, as well as EzDent-i and Ez3D-i software.
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